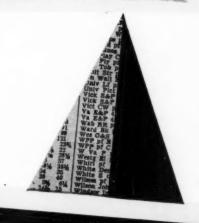
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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JULY, 1957

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The doctor isn't bound by a fee schedule, and the patient pays part of all major bills, under the kind of policy the industry calls 'comprehensive.' In three years it's made a big splash

What Your Delegates Decided167

From labor unions to Social Security referenda, from tax deductions to hospital staff assessments—that's how it went during the A.M.A. delegates' recent week at the Waldorf-Astoria

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A nation-wide survey by the A.M.A.'s Law Department shows malpractice suits are 'the problem of the many, not the few.' Over 14 per cent of the respondents had incurred such claims

- MORE

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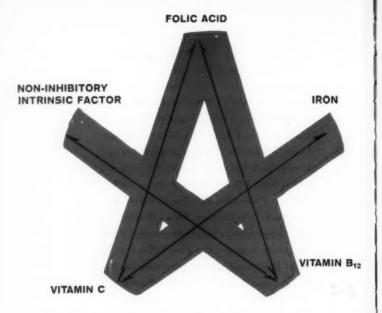
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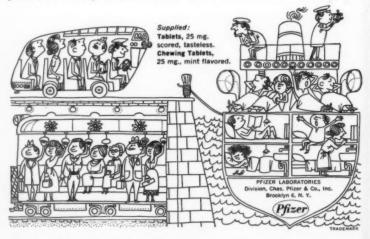
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News

Lawyers' Earnings Lag Behind Physicians'

Until 1941, lawyers ranked ahead of physicians on the professional income ladder. But boom times since then have benefited lawyers less than doctors. Average net earnings among lawyers in private practice stood at \$10,294 in 1954, according to a newly-released study by the U. S. Department of Commerce. The comparable figure for private physicians was over \$17,000, according to MEDICAL ECONOMICS' income studies.

Between salaried lawyers and salaried physicians, the net earnings differential is much narrower: roughly \$10,000 vs. \$12,000. There's a pronounced trend in the legal profession toward salaried work. About one-third of all lawyers are already drawing most of their income from this source, the Department of Commerce says.

In other respects, too, the two professions seem headed in the same direction. For example, a trend away from solo practice is evident in both. One-man law firms accounted for 74 per cent of the lawyers in 1947, but only 65 per cent in 1954. And just as health insurance is looming steadily larger as a source of doctors' incomes, so the corporate client is gaining in importance in the typical legal practice.

Staff Doctors Stir Up a Storm Over Bellevue

Hospital staff physicians have been making king-sized headlines in New York. For weeks the city's newspapers have featured their charges, countercharges, dire warnings, and appeals to public opinion. Subject of all the hullabaloo: New York's huge, hoary Bellevue Hospital.

Bellevue is a place of "crumbling walls" and "disintegrating plumbing," according to the men who work there. They say the fault lies squarely with New York City's bureaucracy. And for the past two

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months, they've been saying it loudly and in public.

Toward the end of April, for the second time within a year, a Belle-

vue elevator fell to the bottom of its shaft. Dr. Dickinson W. Richards, director of the Columbia University unit at the hospital, viewed this as the last straw. In a public re-

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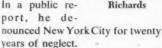
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"The city allows us neither the physical facilities nor the personnel to permit adequate care," he said. "We need, at the earliest possible moment, a whole new hospital."

Dr. Richards went on to itemize "the most disheartening conditions" under which Bellevue doctors work: a shortage of essential medicines such as insulin; so few auxiliary personnel that internes and residents are forced to spend hours each week working as orderlies; laboratories that aren't equipped to make routine tests;



Jacobs

patient crowding over the maximum safety limit -to say nothing of fire hazards, antiquated power system, rust in the pipes, and dry rot in the walls. Dr. Morris A. Jacobs, newly-appointed

Commissioner of Hospitals, denied these charges vigorously. Dr. Richard's remarks were "largely untrue, half-truths, or innuendos," Dr. Jacobs claimed. He pointed out that just a week earlier the city had "appropriated \$85,000 for an architect's study of new construction and reconstruction at Bellevue."

But then Bellevue's House Staff Council, representing 450 internes and residents, released a statement that Dr. Richards' accusations "if anything, were conservative." The city had "shamefully neglected" Bellevue, said the house staff. The medical faculties of Cornell and New York University also endorsed Dr. Richards' charges.

Meanwhile, the hospital's eight medical chiefs decried the city's \$85,000 appropriation for architectural studies. "In 1940, and again in 1946," they noted, "architectural plans for a new hospital were actually completed." And Dr. Robert Boggs, a former N.Y.U. dean, pointed out that "some years back a \$150,000,000 bond issue was floated to replace and rebuild some of the city hospitals. Bellevue, under the agreement then in force, was to be completely rebuilt. These funds were diverted elsewhere, notably to the East Bronx."

During following weeks, Dr. Arthur Zitrin, director of Bellevue's psychiatric division, complained that overcrowding in his department was hampering doctors' efforts to care for patients. ("Overcrowding in the psychiatric service . . . has been with us a long time." Commissioner Jacobs replied.) Dr. Elaine P. Ralli, head of Bellevue's out-patient division, said that for six consecutive years she'd been protesting the dangerous overcrowding of Bellevue's outpatient clinics. (Replied Commissioner Jacobs: "While it is true that there is overcrowding in the

Bellevue out-patient department, we have carefully watched this situation . . .")

By late May, though doctors continued to write angry letters to the newspapers, the storm had blown over onto the back pagesand into higher political circles. Mayor Robert Wagner received a report from Commissioner Jacobs that physical conditions at Bellevue are indeed rather bad. But they've been that way since 1922, he said, and patients continue to get the best of care. As for the falling elevator, he added, it had been overloaded by its operator; the man has since been dismissed from his job.

Jenkins-Keogh-Type Law Approved—in Canada

U. S. doctors urging passage of the Jenkins-Keogh bill can draw encouragement from the success of their Canadian colleagues in a similar campaign. After years of debate, Canada has finally lightened the tax load on retirement savings.

The privilege that Canadian doctors now enjoy is roughly similar to what you'll get if the Jenkins-Keogh bill passes. Each year they're permitted to set aside, taxfree, 10 per cent of gross income (up to a limit of \$2,500) if they put it into an approved type of retirement annuity. (The Jenkins-Keogh bill proposes tax-free setWe're troubled with a quandary syndrome

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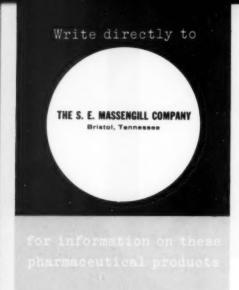
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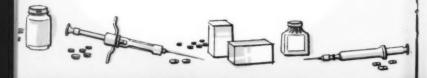
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asides of 10 per cent of *net* income, up to a limit of \$5,000 annually.)

There's one major difference between the U. S. proposal and the Canadian plan: In this country, the Jenkins-Keogh bill would apply only to the self-employed. The new Canadian law permits any taxpayer to put up to 10 per cent of his income into a tax-exempt annuity of his own choosing.

Malpractice Mishaps Reach the Screen

At the A.M.A. convention last month, most delegates spent at least half an hour at the movies. They were previewing "The Doctor Defendant"—second of six medicolegal films being produced by the Wm. S. Merrell Company in cooperation with the A.M.A. and the American Bar Association.

The new film dramatizes the work of a county medical society's defense committee. It follows the committee's investigation of four different cases:

- 1. A radiologist treated a patient successfully for cancer of the cervix. He was sued for malpractice because of the radiation burns his treatment caused. (He wins because, as it turns out, he sent the patient a letter warning her in advance of this hazard.)
- A doctor relied on an outmoded blood test done in his office and neglected to read hospital lab-

oratory findings before doing a hysterectomy. (He loses the resulting suit.)

- 3. A physician examined a botched-up Colles' fracture and told the patient that the doctor responsible for it "didn't know his business." This encouraged the patient to sue. (Upshot: The patient himself is held responsible for the poor result, because it can be proved he didn't follow his doctor's orders.)
- 4. A doctor tried to handle a case by telephone. It turned out the patient had a ruptured appendix. After he died of peritonitis, the wife sued. (The doctor is held accountable.)²

Beginning this month, the movie is available from the A.M.A. Film Library and the Wm. S. Merrell Company, Cincinnati 15, Ohio, for medical society showings.

Subscribers Turn Against Closed-Panel Medicine

Shortly after World War II, New York City agreed to share the cost of comprehensive health benefits for many of its municipal employes. The closed-panel Health Insurance Plan of Greater New York (H.I.P.) was selected as the insurance carrier. Now, after a tenyear trial, some of the subscribers

¹See "The Case of the Outmoded Blood Test." MEDICAL ECONOMICS, January, 1957. ²See "I Was Sued for Malpractice," MED-ICAL ECONOMICS, December, 1956.

are objecting to this H.I.P. "mon-

In a statement addressed to the city's Board of Estimate, the High School Teachers Association de-

clares that "every monopoly is inherently bad. The H.I.P. monopoly has resulted in many complaints of callous disregard, arrogance, cliniclike treatment, too much telephone

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TV in the Treatment Room



To divert waiting patients, a number of doctors have installed TV in their reception rooms. It remained for Dr. G. M. Feigen of San Francisco to extend the idea into his treatment rooms. He's a proctologist; his patients often have to wait ten or fifteen minutes in the treatment room while topical anesthesia is taking effect or while other preparations for treatment are being made. "As the minutes drag along," he says, "their anxieties increase." At least they did until the doctor installed a small portable TV set in each treatment room. "It seems to take the curse off waiting," he reports. He turns the set off when he's ready to begin actual treatment.

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The teachers urge the city to recognize "the American ideal of competition" by permitting all city employes a free choice between H.I.P. and other health plans. Competition, they argue, will compel H.I.P. "to provide the kind of services we were led to expect."

This appeal is based on a poll of one-fifth of New York's high-school teachers. Out of 1,612 teachers questioned, 1,180 were H.I.P. subscribers. Of these, only 580—less than half—rated H.I.P. services as "better than" or "as good as . . . private, free-choice doctor service." Exactly 257 said they were altogether dissatisfied.

A breakdown of specific gripes about H.I.P. service shows that:

317 complained of "lack of personal interest."

287 complained of "overlong waiting" in the doctor's office.

277 complained of "inadequate examination" by the doctor.

207 complained of "overcrowding" in the doctor's office.

203 complained of a "long wait to learn of tests and results."

Other frequently recurring objections, the teachers' association reports, were that H.I.P. physicians treat patients like charity cases and that they subject patients to "assembly-line examinations" in order

to leave time for their private pa-

After the teachers had tabulated their poll, they showed the results to Dr. George Baehr, medical director of H.I.P. "Dr. Baehr proved most cooperative and anxious to improve services complained about," the teachers' subsequent statement says. "However, we question the power of Dr. Baehr to implement any remedial measures... It is our distinct feeling that the parent organization of H.I.P. does not exercise the . . . supervisory power necessary to clean up [these] conditions."

What's needed, they conclude, is some wholesome competition. And a government investigation might help too: "The time has come for our New York City administration to ascertain, through inspection and investigation, the quality [of H.I.P.] service . . . to the 93,300 subscribers and their families for whom the city contributed \$6,500,000 toward premiums last year."

'Crystal-Ball Committee' Urged on Doctors

Both the profession and the public "want something better" in the way of medical service, says an editorial in Medical Annals of the District of Columbia. And unless doctors "assume leadership and help develop the trends properly," the re-

unique derivative of Rauwolfia canescens

Harmonyl'

of the rauwolfias with a new freedom from side effects

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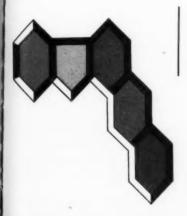
Pa alert chron treat patie side group symp bizar Harmonyl makes rauwolfia more useful in your everyday practice. Two years of clinical evaluation have shown this new alkaloid exhibits significantly fewer and milder side effects than reserpine. Yet, Harmonyl compares to the most potent forms of rauwolfia in effectiveness.

Most significant: Harmonyl causes less mental and physical depression —and far less of the lethargy seen with many rauwolfia preparations.

Patients became more lucid and alert, for example, in a study¹ of chronically ill, agitated senile cases treated with Harmonyl. And these patients were completely free from side effects—although a similar group on reserpine developed such symptoms as anorexia, headache, bizarre dreams, shakes, nausea.

Harmonyl has also demonstrated its potency and relative freedom from side effects in hypertension. In a study comparing various forms of rauwolfia2, the investigators reported deserpidine "an effective agent in reducing the blood pressure of the hypertensive patient both in the mild to moderate, as well as the severe form of hypertension." They also noted that side reactions were "less annoying and somewhat less frequent" with this new alkaloid. Other studies confirm that few cases of giddiness. vertigo or sense of detached existence are seen with Harmonyl.

Professional literature with complete information on this unique new rauwolfia derivative is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg. and 1-mg. tablets.



References: 1. Communication to Abbott Laboratories, 1956. 2. Moyer, J. H. et al: Deserpidine for the Treatment of Hypertension, Southern Medical J., 50:499, April, 1957.



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New Evidence on Estrogens for Control of B LEEDING

Now, for the first time, a new study defines the effect of intravenous estrogens in increasing the coagulability of the blood, and confirms the empirical success of estrogens in controlling spontaneous hemorrhage.

Within 15 minutes after administration of "PREMARIN" INTRAVENOUS, three important factors of the blood coagulation mechanism were affected:

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sulting changes may not be to most doctors' liking.

In the past, the editorial points out, "organized medicine has done little more than object to proposals ... usually with very good reasons. But what has it offered as solutions? It is high time it took a positive stand instead of largely a negative one."

A good place to begin is the local level, the editorial writer suggests: "Among the thirty-four committees of the Medical Society of the District of Columbia . . . not one is greatly concerned with the broad aspects of the future of medical practice. Is it not advisable to have a committee whose function is solely to study trends, to try to look into the future? . . .

"Such a committee—call it what you may—should be composed of a few carefully selected men... who would sit down and mull over the problems confronting us and ... look into the 'crystal ball' for the answers."

Only by such "dedicated effort," concludes the editorial, can doctors control the changes that are bound to come.

Patients Given Tips on Telephone Technique

What do you do when patients take up your time with routine phone calls?

For two New Orleans doctors who share a thriving pediatrics practice, the answer was to write

prescribe RAUDIXIN to break the mental tension—hypertension cycle



*Raudixin reduces mental tension

Tranquilizing Raudixin reduces the mental tension which plays a significant role in hypertension ... reduces mental tension as yet unrelated to physical symptoms.

*Raudixin reduces hypertension

Blood pressure lowering effect is gradual, sustained in hypertensives...little or no hypotensive effect is produced in normotensives.

*Single daily dosage discourages promiscuous overuse by patients...not habit-forming.

RAUDIXIN

SQUIBB



Squibb Quality-the Priceless Ingredient

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"A Letter to Our Patients" about it.

"We receive over fifty phone calls a day," they wrote. "If each call averages five minutes, it is . . . impossible to see any patients."

Too often, they said, patients make it a "point of honor" to speak personally to the doctor about minor matters. "Please don't," they asked. "The office staff are all trained and experienced to relay routine questions to us and give our answers.

"In order to give each patient good and prompt service," they continued, "we ask parents to state the nature of their calls to the staff. When we receive a message, 'Call Mrs. Doe at Bywater 7000,' we do not know if the child has a 105-degree temperature or if the mother wishes to know how much codliver oil to give him . . .

"Try to think out questions in advance," they went on. "Before calling about a prescription, have at hand a pencil, paper, and your druggist's telephone number . . . If you can limit each call to three minutes, we'll be able to give better medical service to everyone."

Court Slaps Down V.A. In Insurance Case

Can V.A. hospitals collect on insurance policies carried by veterans for whom they provide medical care?

The V.A. says yes—provided the veteran signs over his policy rights. But two years ago, in a test case, a U.S. district court ruled that an insurance company was not required to pay. Now, in another test case, a U.S. Court of Appeals has arrived at exactly the same conclusion.

Lawyer Luke A. Burke reports on the case in a recent issue of The Spectator: "A veteran of World War II was affected with poliomyelitis and admitted to a Veterans Hospital . . . He remained for about a year . . . He had insurance at the time in the form of a 'poliomyelitis expense policy' [that would] pay him 'for expenses actually incurred'

"The Veterans Administration had taken an assignment from him of his rights under the policy . . . and made claim under the policy. The insurer refused to recognize the charges as 'expenses actually incurred by the insured' upon the ground that . . . as a veteran [he had been] entitled to free care."

Whereupon the Government brought suit against the insurance company. But the courts ruled in favor of the company, saying: "The veteran had a right under his policy to have the insurer pay him only 'for expenses actually incurred' by him." That didn't include "what he was entitled . . . to have furnished to him as a veteran . . . " [MORE NEWS ON 278]

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24 steps to a hospital bed

The commonest task, such as climbing a flight of stairs, confronts the angina pectoris patient with a fearful question: "Will I be able to make it?"

Exertion leads to attacks . . . and fear of attacks leads to an increasing restriction of activities. Ultimately, even the attack-free intervals may lose all semblance of normal living.

Remove the fear factor. In 4 out of 5 patients, routine prophylaxis utilizing Peritrate reduces the incidence and severity of anginal attacks, improves abnormal EKG tracings and increases exercise tolerance.

A new sense of freedom restores the "cardiac cripple" to a sense of usefulness and participation, although he

should not now indulge in previously prohibited strenuous exercise.

Peritrate prophylaxis is simple: 10 or 20 mg. before meals and at bedtime. The specific needs of most patients are met with Peritrate's five convenient dosage forms: Peritrate 10 mg. and 20 mg. tablets; Peritrate Delayed Action (10 mg.) for protection continued through the night; Peritrate with Phenobarbital (10 mg. with phenobarbital 15 mg.) where sedation is also required; Peritrate with Aminophylline (10 mg. with aminophylline 100 mg.) in cardiac and circulatory insufficiency.

Usual Dosage: A continuous schedule of 10 to 20 mg. before meals and at bedtime.

Peritrate[®]

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she needs support, too during pregnancy and throughout lactation

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VITAMIN-MINERAL COMBINATION

NATABEC Kapseals supply vitamins and minerals in a carefully balanced formula that helps to provide nutritional support for the gravida and for the nursing mother. As a dietary supplement, NATABEC helps to promote better present and future health for the mother and for her child.

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"...Of 90 patients with low back pain and other muscular conditions...
67 (74 per cent) showed a good response..."

"...17 of...20 patients with post-traumatic muscle spasm of the low back had excellent or good responses."²

(1) Johnson, H. J., Jr.: To be published. (2) Wallace, S. L.: To be published.

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Pink, Enteric Coated tablets (250 mg.), bottles of 36. Yellow, scored tablets (250 mg.), bottles of 50.

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"Makes Dictation Easy as Talking to an Old Friend"



All controls are in the palm of your hand ... with UNIMATIC REMOTE CONTROL MICROPHONE



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The excellent results with Zanchol in surgical gallbladder cases have been most pronounced in two phases of management:

1. Early—Zanchol in Postoperative Care. T-tube studies have demonstrated that Zanchol increases the volume and fluidity of bile, at the same time changing its color to a clear, brilliant green. The greatly improved abstergent cleansing

action of the bile is noted in its ability to keep the T tubes clean without rinsing in most cases.¹

2. Late — Zanchol in Post-cholecystectomy Syndrome. By improving the physico-chemical properties of bile and increasing its flow, Zanchol acts to eliminate biliary stasis and sharply reduce or eliminate biliary sediment. The drug may be employed in both prophylaxis

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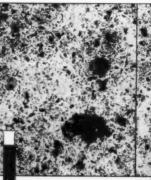
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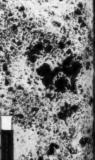
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photomicrographs'

showing daily changes in sediment from centrifuged bile taken from T-tube drainage in a postcholecystectomized patient.



First day, before administration of Zanchol.



Second day, after Zanchol administration

Synthetic Biliary Abstergent Fills an Important Post-cholecystectomy Need

and therapy of the post-cholecystectomy syndrome.

Indications for Zanchol

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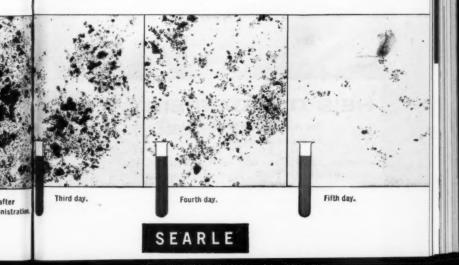
- Postoperative cholecystectomy care;
- Routine long-term post-cholecystectomy care;
- Chronic cholecystitis cases in which surgery is not indicated.

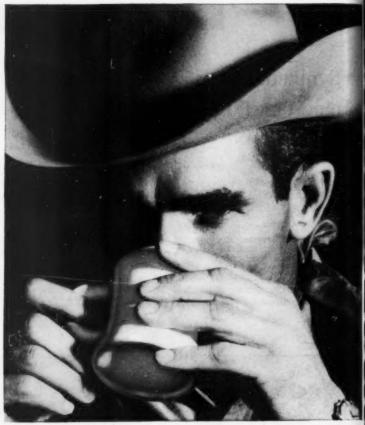
Dosage: one tablet three or four times daily.

Supplied: Zanchol is available in tablets of 250 mg. each.

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 McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. 103:163 (Aug.) 1956.





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but he still enjoys his coffee as much as ever!

Hearty...robust...full man-sized flavor! That's new Instant Sanka Coffee. No matter how much coffee your patients like to drink...Instant Sanka can't get on their nerves or keep them awake. All pure coffee. 97% caffein-free.



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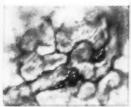
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excellent response in eczematous dermatoses

Meti-Derm CREAM 0.5%

(METICORTELONE, free alcohol)

water washable—stainless benefits allergic dermatoses, usually without irritation

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with Neomycin

5 mg. METICORTELONE and 5 mg. Neomycin Sulfate advantageous when infection is present or suspected

Each in 10 Gm. tubes

Mati-Daem,* brond of prednisolone topical.
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New mothers sometimes think preparing an evaporated milk formula is more complicated than proprietary formulas.

Actually, since sterilization is the same, the *only* difference is that the mother adds the carbohydrate...the specific type and amount *prescribed by the physician* as best for her baby.

This gives the infant the advantages of his own evaporated milk prescription formula, readily adjustable to meet his changing nutritional needs – a *flexibility* not possible with proprietary formulas.

The mother who knows this will not consider adding the carbohydrate any "trouble" at all!



Optimum prescriptionquality in today's trend to the individualized formula.



MEDICAL ECONOMICS - JULY 1957 35

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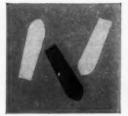


a full day's work in comfort for people troubled with hemorrhoids

Offering greater convenience and accuracy of dosage, Nupercainal Suppositories give the same prompt, safe, lasting relief from discomfort of hemorrhoids so long associated with Nupercainal Ointment. Nupercainal Suppositories relieve the itching, burning, and pain of hemorrhoids - yet contain no narcotics to mask serious rectal disease.

Supply: Nupercainal Suppositories, each containing Nupercaine base 2.5 mg., zinc oxide, bismuth subgallate, acetone sodium bisulfite 0.05% (as a preservative) and cocoa butter; boxes of 12.

Also available: Nupercainal Ointment and Cream.



New Nupercainal (dibucaine CIBA)

CIBA SUMMIT. N. J.

Suppositories

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for the child who "just won't eat"

In a one-year, controlled study of children with secondary growth failure or clinical malnutrition, 'Trophite' -high dosage of B12 and B1-increased growth by nearly 50% (see graph below).

AVERAGE GROWTH AND DEVELOPMENT RATE - LEVELS/YEAR

Pre-treatment vear

growth without 'Trophite' in below-par children

Treatment year

growth with 'Trophite' in below-par children

(These levels represent growth in terms of both height and weight according to Wetzel's Grid technique.)

Try 'Trophite' in the child who "just won't eat." Both you and his parents will be delighted with his new appetite.

> 'Trophite' is available both as a truly delicious liquid and as tablets. Each teaspoonful (5 cc.) or tablet supplies: 25 mcg. B₁₂, 10 mg. B₁.

> > the high potency combination of B_{12} and B_{1}

Trophite*

for appetite

*T.M. Reg. U.S. Pat. Off. Smith, Kline & French Laboratories, Philadelphia

MEDICAL ECONOMICS · JULY 1957 37



THE SHOE THAT UNDERSTANDS CHILDREN

. . . knows that it's never too warm for the right kind of shoes, summer Stride Rites . . . light and cool styles, yet built to offer firm support, built to fit and hold their shape. You can recommend them with confidence, as so many doctors do . . . knowing there should be no vacation from proper foot-protection, no matter how high the temperature!

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DOCTOR: If you are not already familiar with Stride Rites, and Stride Rite Shoes with Extra Support. on for information to: Green Shoe Mfg. Co., 966 Harrison Avenue, Boston, Massachusetts.



The Ritter Examining and eatment Table enables the physician to treat more patients, more thoroughly with less effort in less time

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Not a "caine" derivative. Good relief was provided in more than 15,600 case studies. Sensitization was negligible, and neither toxicity nor cross-sensitization was observed. (Abbett

new assurance
for the aged with
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...to promote prompt recovery
and greater freedom from
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Supplied: Boxes of ten 1.3 cc. ampuls

C.V.P. is not a single bioflavonoid. It is a naturally occurring soluble complex which includes a number of biologically active bioflavonoids from citrus sourcesavailable exclusively in C.V.P.-combined with ascorbic acid. C.V.P. is water-soluble, and is thus more readily absorbed and clinically active than relatively insoluble rutin and purified hesperidin.



Each C.V.P. capsule or each 5 cc. of syrup (approx. one teaspoonful) provides

CITRUS	BIOFLAVONOID COMPOUN	100 mg.
ASCORB	IC ACID (vitamin' C)	100 mg.

Bettles of 100, 500, and 1,000 capsules; 4 oz., 16 oz. and gallon syrup.

SAMPLES and reprint on request.

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Sokoloff, B., Martin, W. C., and Saeihoff, E. C.: Journal American Geriatric Society, 5:306, March 1957.
 Alvarez, W. C.: Journal American Medical Association, 157:1199, 1955.

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new clinical study¹ demonstrates value of capillary-protectant

(water-soluble biologically active citrus bioflavonoid compound with vitamin C)

in helping reduce incidence of

Alvarez² considers "little strokes," with resultant personality changes, emotional disturbance, and mental deterioration, one of the commonest diseases of aging man.

Based on the belief that increased capillary permeability and fragility appear to be underlying factors in producing capillary rupture and "little strokes," investigators administered capillary protectant C.V.P. to thirteen patients who had previously suffered "little strokes." (Dose: 600 mg. C.V.P. or 6 capsules daily.)

results with C.V.P.

"The results in this small number of patients seem to indicate a beneficial effect of bioflavonoid therapy on the course of 'little strokes'" and "emphasize as well the important role, which increased capillary fragility appears to play in this illness." In ten of the thirteen patients there was no further occurrence of "little strokes," and their conditions were "improved," "good," "satisfactory," or "excellent."



each tablet contains:

MECLIZINE (12.5 mg.) – specifically suppresses labyrinthine irritation¹

NICOTINIC ACID (50 mg.)—for prompt increase of cerebral blood flow²

Proof? Try antivert on your next vertiginous patient. One tablet t.i.d. before meals. In bottles of 100 blue-and-white scored tablets. Rx only.



(AND A GLANCE AT THE FORMULA SHOWS 2 REASONS WHY)

CHICAGO 11, ILLINOIS

VERTIGO IN GERIATRICS
ANTIVERT is particularly useful for the relief of vertigo in the aging.

1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952.

44 MEDICAL ECONOMICS · JULY 1957

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DEAR DOCTOR . . . HAVE YOU EVER THOUGHT of OWNING a BUSINESS, TOO?

Professional men have found owning this business an attractive way to acquire equity and security without distraction from private practises



Laundry stores began to boom in 1946. and ten years later, over 15,000 laundry stores are serving millions of satisfied

Today, a new type of Laundry Store—THE COIN-OPERATED COMPLETELY UNATTENDED WESTINGHOUSE LAUNDROMAT—is springing up all over America. Originating in Texas less than two years ago, these automatic self-service laundry stores have spread through Florida, California . . . and are now being chain-operated in Illinois and Missouri.

You, too, can get in on this most profitable mushrooming business in your spare time . . . and with a very modest investment.

Briefly, here's what it's all about:

- dry. We don't know why, but it s a fact . . . and they flock to unattended laundry stores where they do-it-themselves . . . using their own choice of soap and other washing mate-
- 2 Laundry is a necessity and people, especially in the lower income groups, will walk 3 or 4 extra blocks TO SAVE ALMOST 50% on their weekly laundry bill.
- 3 Bachelors, career girls, students and working families can only do laundry during hours when regular laundry stores are closed . AN UNATTENDED LAUNDRY IS OFTEN OPEN 24 HOURS A DAY, 7 DAYS A WEEK. Profits are realized in night and weekend hours when other laundries are closed.
- 4 Washers and dryers are coin-metered... 8 And EACH STORE PROVIDES YOU WITH AN everything works automatically...you 8 INCOME OF \$4000-\$8000 a year, depending empty the coin boxes 2 or 3 times a month.

- Many women prefer to do their own laun-dry. We don't know why, but it's a fact... 5 Machine service and daily maintenance is contracted out to your local repairman and local porter. You visit the store only to collect the coins.
 - 6 Depreciation of equipment for tax purposes is rapid, and within a relatively short period of time you own a going business that ACTUALLY RUNS ITSELF.
 - Because it takes so little of your time to operate, it does not interfere with your regular business. Because of almost absentee management, no customer contact, and favorable depreciation schedules, it is perfect for chain-store operation.
 - on location and equipment

There's a great deal more to this story that you should know. We'd like the oppor-tunity of giving you all the important investment details. It'll take about an hour of your time.

This we do know! You will add Thousands of Dollars to your present income every year. Your community wants and needs an UNATTENDED, COIN-OPERATED WESTINGHOUSE LAUNDROMAT STORE. As a doctor, you may find this the extra business opportunity you've been looking for.

We offer advice, store planning, training and advertising. WE WILL FINANCE up to 80% of the NECESSARY EQUIPMENT. Do take a look at this investment . . . it'll make a difference to you.

Call, wire or write. We'd like to set a date at your convenience and show you some COIN-METERED LAUNDRY STORES in your area. We have representatives throughout the United States.

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MEDICAL ECONOMICS · JULY 1957 45

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How to win friends ...



The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (11/4 grs. each).

We will be pleased to send samples on request.

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KNOX PROTEIN PREVIEWS

Overcoming Today's No. 1 Nutritional Problem

Knox "Choice of Foods" Diet Can Help Your CARDIAC Patients Lose Weight Successfully



- 1. Color-coded diets of 1200, 1600 and 1800 calories are based on nutritionally-sound Food Exchanges.
- 2. Easy-to-use Food Exchanges (referred to in the Knox booklet as Choices) eliminate calorie counting by patient.
- 3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

considerable latitude in food choice.

4. More than six dozen appetizing, lowcalorie recipes are presented on the last 14 pages of each diet booklet.

Chas. B. Knox Gelatine Co., Inc. Professional Service Dept. ME-22 Johnstown, N. Y.

Please send me dozen copies of the new illustrated Knox Reducing booklet based on Food Exchanges.

Your Name and Address

Letters

Short-Order Medicine?

SIRS: In a recent View, you suggested that a routine office visit often isn't enough; nor is a routine office visit fee. That's quite true. It's also true, as you stated, that more time spent with patients means better-satisfied patients. But the fee-for-service concept does not apply to full-service-type health plans. The doctor who takes part in such a plan isn't recompensed for spending extra time with his patients.

In my locale, the health plan's fee for a return office visit is less than \$3-even for internists. So most physicians must depend on volume.

The American public may be complaining of short-order medicine, as you say. But it's also clamoring for full-service health insurance. Unfortunately, the two all too frequently go hand-in-hand. What's more, full-service coverage is expanding rapidly. The resultant increase in the number of dissatisfied patients should provide a fertile field for the cultist.

> Rolf H. Pratum, M.D. Bellingham, Wash.

Sirs: In a recent Letter, Dr. W. A. Kilduff criticized a physician who'd reported that his "average house call took twenty-eight minutes, of which sixteen went into traveling time." I disagree with Dr. Kilduff's idea that such a short house call necessarily constitutes "productionline" medicine.

I'd like to ask how much time he needs to diagnose tonsillitis, measles, otitis, scarlet fever, or pneumonia.

Personally, I think twelve minutes are enough to diagnose and treat most of the above diseasesand arrange hospitalization if necessary-with some time left over for a social visit.

Like Dr. Kilduff, I abhor the thought of production-line practice. I've spent as much as an hour and a quarter with a patient and her husband just explaining physical I do a lo ing

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cal and psychological findings. But I don't think it's necessary to spend a lot of time diagnosing and treating the average house-call case.

> N. M. Camardese, M.D. Norwalk, Ohio

Reuther's Two Ideas

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SIRS: I see by the papers that Walter Reuther is prepared to bargain with the auto manufacturers for "a four-day week, presumably of thirty-two hours, plus a substantial increase in the take-home pay now received for a five-day, forty-hour week."

And I see by MEDICAL ECO-NOMICS that Mr. Reuther is eager to establish a comprehensive, prepaid medical plan in Michigan.

Mr. Reuther is to be congratulated on his two excellent ideas. If he'll agree to pay me a substantial increase in take-home pay and reduce my work-week from the present seventy to thirty-two hours -and if he'll give me a contract containing an escalator clause tied to the cost of living-I for one will be glad to sign up with his plan.

Why doesn't the Michigan Medical Society adopt this principle as a minimum condition of cooperation when they start bargaining in earnest with Mr. Reuther?

> Lyon Steine, M.D. Valley Stream, N.Y.

Ideal Location?

"How I Found the Ideal Place to Practice" fascinated meespecially the O. Henry ending. It's interesting to note that Dr. Bowes' final choice (Salt Lake City) wasn't even on his list of candidate-cities. It was chosen as most of us choose our wives: by accidental selection.

This reminds me of the classic story about three partners who planned to hire a new secretary: They narrowed the field down to three girls, whose qualifications and references they then investigated at length. Which one did they finally pick? Why, the one with the Jayne Mansfield facade, of course.

Anyway, Dr. Bowes' persever-

ance bespeaks a thoroughgoing scientific personality. He deserves a rewarding career, and I think he'll get it. I grew up in Salt Lake City and can vouch for the charm of the place.

Abe Cline, M.D. Los Angeles, Calif.

Cover Puzzler

SIRS: I'm intrigued by your April cover. But what is that small circle over the doctor's head? If it's a halo, it should be larger and bright-



er. If it's a bubble, it should be smaller. If it's an idea, what's the idea?

Duncan C. McKeever, M.D. Houston, Tex.

Georg Olden, who created this portrait of a physician doing everything himself, explains that the "small circle" is a head mirror designed especially for six-armed doctors.-ED.

Malpractice Problems

SIRS: I've just read "The Case of the Improved Record." Was the jury's decision in this malpractice case based entirely on the doctor's apparent use of two different pens and inks on the patient's record?

This seems to be rather farfetched circumstantial evidence on which to base a decision against the doctor. Many physicians use various pens and inks at different places in their offices.

> Charles W. Hawkins, M.D. Chattanooga, Tenn.

The author comments: "Remember that the doctor in this case had altered the record. His manner in court, plus the arguments of the plaintiff's attorney, convinced the jury that the evidence was conclusive."-ED.

SIRS: "What Price Malpractice Insurance?" paints an ugly picture of the malpractice situation in Oregon. It shows that National Bureau rates are up 41 per cent in this state. And it lists Oregon among four areas that are "apparently the country's worst malpractice trouble spots."

Actually, by setting up our own medical society program through a carrier that doesn't belong to the HEALTH CENTER LIBRARY



in hay fever



Novahistine[®]

(PITMAN-MOORE)

gives greater relief
than antihistamines alone
... and avoids misuse of topical agents

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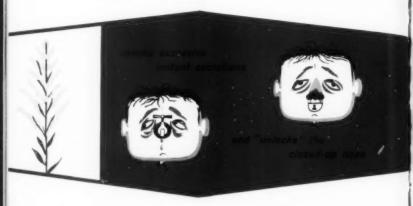
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Novahistine



. . . gives greater relief than antihistamines alone

In the management of hay fever and other seasonal allergies . . . as well as the common cold . . . the distinctly additive action of a vasoconstrictor (phenylephrine HCl) combined with an antihistaminic drug (prophenpyridamine) produces a higher degree of relief than either drug given alone.

. . . eliminates patient misuse of nose drops, sprays and

inhalants . . . avoids the risk of rebound congestion, mucosal damage, and ciliary paralysis. Novahistine will not cause jitters or insomnia . . . will not depress the appetite.

Each pleasant-tasting teaspoonful of Novahistine Elixir provides 5.0 mg. of phenylephrine HCl and 12.5 mg. prophenpyridamine.

Novahistine Fortis Capsules provide twice the amount of phenylephrine for more potent nasal decongestion.

OTHER DOSAGE FORMS

NOVAHISTINE Tablets
NOVAHISTINE with APC Capsules
NOVAHISTINE with Penicillin Capsules
NOVAHISTINE-DH



PITMAN-MOORE COMPANY

DIVISION OF ALLIED LABORATORIES, INC. . INDIANAPOLIS, INDIANA

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The erutions of psoriasis may disappear in the summer, to reappear in the winter (Madden¹). According to Morris², "the best security against relapse is the completest possible removal of all remnants of the disease."

To avoid recurrence in the fall, psoriasis should be treated intensively with RIASOL all summer. Treatment should be continued until every patch, papule, scale and "bleeding point" has been eradicated.

Permanent results with RIASOL may be secured when it is used conscientiously during the declining phase of psoriasis. Many physicians have reported freedom from relapses lasting years after a course of RIASOL treatment.

RIASOL* contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-stain-

ing, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

After one week, adjust to patient's progress.
RIASOL is supplied in 4 and 8 fld. oz.
bottles at pharmacies or direct.

¹ Minnesota Med. 22:381, 1939, ² Brit. M. J. 2:1328, 1954. *T.M. Reg. U. S. Pat. Off.

Test RIASOL Yourself



MAY WE SEND you professional literature and generous clinical package of RIASOL. No obligation. Write

SHIELD LABORATORIES
Dept. ME-757

12850 Mansfield Avenue Detroit 27, Michigan



BEFORE USE OF RIASOL



AFTER USE OF RIASOL

RIASOL FOR PSORIASIS

National Bureau, most of us have been able to get our premiums reduced twice in the past two years. We now pay only about half the National Bureau rate.

> John M. Hoffman, M.D. McMinnville, Ore.

Why Women Earn Less

SIRS: As a woman M.D. I'm concerned about the reports that women generally have smaller and less lucrative practices than men. I'm sure these reports are true. But do you know why?

Before I went into practice, I decided that if there really was a doctor shortage, a woman should carry at least an average physician's work-load. So I made it my business to get the best training available. I became certified in my specialty. And I set up a wellequipped office in a city where that specialty was needed.

But what's happened? I work a little over forty hours a weekthree-quarters the number of hours my male confrere works. I gross about three-quarters as much as he does. But, with the same overhead, I net only half as much.

You may say I should work longer hours. But when I try, I always hit a snag.

What's the trouble? Ask any physician who in his family buys the groceries and the sheets. Ask

spastic dysmenorrhea

"The most satisfactory antispasmodic."

"Relieves depression as well as pain."2

EDRISAL

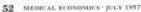
Antispasmodic—Antidepressant—Analgesic

2 tablets every 3 hours

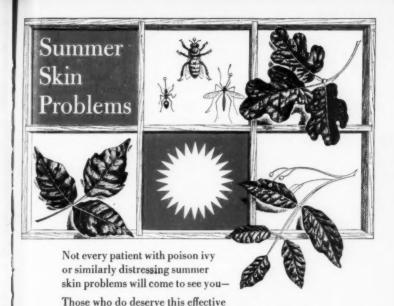
Formula: Benzedrine® Sulfate (racemic amphetamine sulfate, S.K.F.), 2.5 mg.; aspirin, 2.5 gr.; phenacetin, 2.5 gr.

Also available: 'Edrisal with Codeine' (1/4 gr. & 1/2 gr.)

- 1. Janney: Medical Gynecology, ed. 2. 2. Am. J. Obst. & Gynec. 61:1366.



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lotion ointment

Florinef (Squibb Fludrocortisone Acetate) with Spectrocin (Squibb Neomycin-Gramicidin)

treatment which only you can prescribe-

the most effective antipruritic, anti-inflammatory agent known, plus antibiotic action against secondary bacterial invaders

Only 2 or 3 drops of Florinef-S Lotion, or ¼ inch of Florinef-S Ointment, will provide your patients with prompt, welcome relief of itching and inflammation, hasten the healing process, discourage scratching, and act prophylactically or therapeutically against secondary bacterial invaders.

NEVER BEFORE HAS SO LITTLE MEDICATION PROVIDED SO MUCH RELIEF.

Florinef-S Lotion, 0.05% and 0.1%, 15 cc. plastic squeeze bottles; Florinef-S Ointment, 0.1%, 5 Gm. and 20 Gm. tubes.

Also available: Florinef-S Ophthalmic Suspension, 0.1%, 5 cc. dropper bottles; Florinef-S Ophthalmic Ointment, 0.1%, 3.6 Gm. tubes with ophthalmic tip.

SQUIBB



Squibb Quality - the Priceless Ingredient

"FLORINEP" AND SPECTROCIN'S ARE SQUIBS TRADEMARKS

MEDICAL ECONOMICS JULY 1957 53

him who plans the menus, schedules social evenings, invites the guests, sends clothes to the cleaner and shoes to the shoemaker, selects the Christmas cards, and gives the housekeeper her instructions.

I have a secretary, a maid, an accountant, and a man to clean my office. But I'm still the lady of the house, and there are certain jobs I cannot delegate.

It's playing these dual roles that cuts into a woman physician's time more than anything else. I must do many of the jobs that a man would delegate to his wife, his mother, or his club.

Maybe I can persuade a sister or someone to help a little—but nobody can sit under the hair dryer for me.

M.D., New Jersey

Don't Make 'em Decide

SIRS: In "How to Get People to Accept Your Advice," David Rutherford recommends that the patient share in the responsibility for medical decisions. He even suggests that the doctor shape the interview so that his advice appears to come from the patient. I think this is a mistake.

A sick man wants someone else to assume the responsibility for his care. It's unfair—even cowardly—for the M.D. to make him shoulder part of that burden. [MORE]

Physiological
Sleep without
Hangover

Your patient's nerves are steady after a good night's sleep due to BROMIDIA. Quiet and deep sleep occurs within the hour

No drowsy after-effects • No Hangover • Bromidia is a balanced combination of chloral hydrate, potassium bromide and ext. hyoscyamus. The bromide increases and prolongs the hypnotic effect of the chloral hydrate, while the hyoscyamus helps to tranquilize the restless patient.

Available on prescription in 4 fld. oz. and pint bottles.

At all pharmacies

DOSAGE: For insomnia, 1 to 2 teaspoonfuls on retiring. In cases of nervousness, the sedative dose is ½ to 1 teaspoonful repeated up to 3 times daily. Maximum dosage 3 teaspoonfuls per diem.

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Test Bromidia yourself . Mail the coupon

BATTLE & COMPANY 4026 Olive Street, St. Louis 8, Missouri.

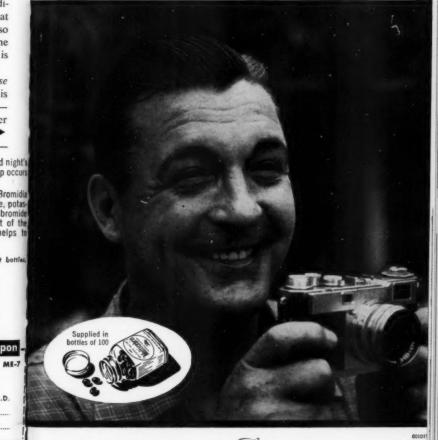
Please send me professional literature and sample of BROMIDIA.

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throughout the adult years

MULTICEBRIN

promotes the health of your well patients



DISTINGUISHED MEMBER OF THE Lilly FAMILY OF VITAMINS

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LETTERS

Under ideal conditions, the patient regards the healer as a Godequivalent, a kind father, someone who knows all. He wants nothing but to relax and let the doctor take care of him. To demand that a sick man make medical decisions for himself, with the physician acting like the moderator on a quiz show, is to blind yourself to the very essence of the doctor-patient relationship.

Henry A. Davidson, M.D. Cedar Grove, N.J

Not Panel Practice?

SIRS: I wish the author of "He Lost His Patients to the Closed-Panel Plans" would give up the term "panel practice" in favor of the more precise term "group practice."

Blue Shield too has a panel of physicians who have agreed to accept a fixed fee schedule; subscribers who want service benefits are limited to the physicians on this panel. The essential difference between a Blue Shield plan and the Health Insurance Plan of Greater New York is not the existence of service panels, but the fact that H.I.P. subscribers receive their services only from doctors who are organized into thirty-two autonomous medical groups.

An article reporting an impartial survey ought to avoid the seman-

Message: WHILE YOU WERE OUT Mrs. Amadeo phoned that the prescription actually seems to irritate her little boy's ivy poisoning. He may be sensitive to the local anesthetic, so I played it safe and suggested she use Calmitol until you returned. TIME: 9:10 a.m. TELEPHONED X PLEASE CALL WILL CALL AGAIN TELEPHONED X PLEASE CALL Source Calmitol appears to relieve hours. Calmitol appears to relieve the itching without complications the itching without complications and 9 told her to continue it. How is our office supply of Calmitol? Lie N.

antipruritic ointment supplied in 1½-oz. tubes and 1-lb. jars, and (liquid) 2-oz. bottles by Thos. Leeming & Co., Inc., New York 17.

MEDICAL ECONOMICS - JULY 1957

your patients
nutritionally

in pregnancy
lactation
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Saturation Dosage

of water-soluble vitamins B and C

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Mononitrate (6,) Hisallovin (6,)

Micotinamida 5 Colcrum Puntothenate 10

Hydrochloride (B₆)

(vitamin C) 350 mg

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tics used by those advocates of solo practice who endeavor to mislead the public by avoiding the use of the proper term: "group practice."

George Baehr, M.D.

President and Medical Director
Health Insurance Plan of Greater New York
New York, N.Y.

Prints His Own Forms

SIRS: Several years ago I invested \$50 in a reconditioned mimeograph machine. It paid for itself in six months and continues to offer advantages. To wit:

I've never been satisfied with the standard give-away instructions turned out by the suppliers of milk, baby food, diet specialties, etc. Also, storage is a problem, for

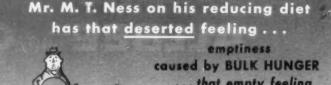
those free pamphlets come in all sizes. Mimeographed copy, by contrast, files nicely in any letter-file.

My instruction sheet to mothers—to name just one handy form—saves me at least thirty minutes worth of verbal instructions (which mothers forget anyway) and several phone calls per new mother.

The machine turns out diet lists, dun letters, history and physical exam forms, and postoperative instructions. My secretary has an idea that we may eventually even work out some way to run insurance forms through it.

Bernard P. Harpole, M.D. Portland, Ore.

END



... that empty feeling

This can be suppressed by

Obocel®

doubles the power to resist food each Obocell tablet contains: Dextro-Amphetamine

Phosphate (dibasic) 5 mg. Nicel* 160 mg.

*Irwin, Neisler's brand of High Viscosity Methylcellulose

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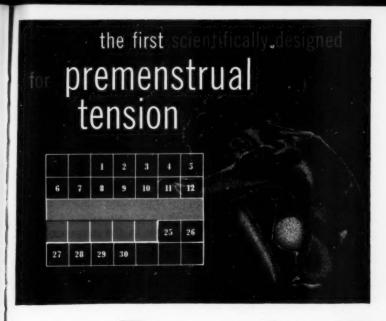
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Brand of Bromaleate, Brayten



NEO BROMTH, the first preparation developed specifically for treatment of premenstrual tension, continues to be found the most satisfactory therapeutic agent in this condition.

Bickers found that "abnormal water storage can be blocked or eliminated and clinical relief of symptoms obtained in most patients . . . "I with NEO BROMTH.

Greenblatt recently stated: "Clinically, we share Bickers' enthusiasm for this drug in the management of premenstrual tension, especially where there is associated edema."2

NEO BROMTH is non-toxic, non-hormonal therapy and contains no ammonium chloride. Each 80 mg. tablet contains 50 mg. of pamabrom (2-amino-2-methyl-1propanol 8 bromo-theophyllinate) and 30 mg. of pyrilamine maleate.

Dosage: 2 tablets twice daily (morning & night) beginning at onset of symptoms -usually 5 to 7 days before menses. Discontinue at onset of flow. Supplied in bottles of 100 tablets on prescription only.

1. Bickers, W .: Southern M.J., 46:873, Sept., 1953 2. Greenblatt, R.: GP, 11:66, March, 1955

BRAYTEN PHARMACEUTICAL COMPANY Chattanooga 9, Tennessee

MEDICAL ECONOMICS · JULY 1957 59

Twin benefits in peptic ulcer therapy

ELORINE CHLORIDE

(Tricyclamol Chloride, Lilly)

reduces gastric secretion and gastro-intestinal motility

Because 'Elorine Chloride' is capable of reducing gastric secretion and decreasing the motility of the gastro-intestinal tract (except the esophagus), it is especially valuable in the management of peptic ulcer. Other indications for 'Elorine Chloride' are functional digestive disorders, acute pancreatitis, diverticulitis, pylorospasm, and excessive sweating.

Effective in peptic ulcer therapy

In a comprehensive study of anticholinergic agents, Sun and Shay¹ investigated the effect of a single "optimal effective dose" (O.E.D.) on basal gastric secretion. Under study were twenty-two patients with chronic duodenal ulcers which were secreting acid gastric juice continuously. The patients also received isotonic sodium chloride solution to rule out psychogenic factors. All drugs were administered intraduodenally. Results showed that 'Elorine Sulfate'* produced a "pronounced and significant" decrease in mean gastric volume, free and total acid, and pepsin output.

Longer suppression of gastric acidity

Duration of suppression of acidity was measured in sixteen patients. 'Elorine Sulfate' reduced gastric acidity to ph 4.5 or higher in all sixteen patients. This reduction was maintained from 30 to more than 270 minutes. In nine of the sixteen patients it lasted longer than three hours. The O.E.D. for 'Elorine Sulfate' varied from 150 to 500 mg.; this emphasizes the need for individual dosing.

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^{*}The 'Elorine Sulfate' (Tricyclamol Sulfate, Lilly) used in this study is therapeutically identical with 'Elorine Chloride' now available,

Decreases basal secretion in emotional stress

In another phase of their investigation, Sun and Shay studied the effect of 'Elorine Sulfate' on gastric secretion stimulated by emotional stress.

One hour's basal secretion was collected. A disturbing thirty-minute interview based on a previously determined conflict was then conducted by a psychiatrist. Control basal secretion and secretion after emotional stress and after emotional stress plus 'Elorine Sulfate' intraduodenally were plotted.

In the stress situation without 'Elorine Sulfate,' an initial depression of gastric secretion was followed by a 700 percent increase in mean basal secretion during the third and fourth peak hours. The administration of 'Elorine Sulfate,' on the other hand, inhibited gastric secretion throughout the four-hour period following the interview.

Dosage must be tailored to the patient

An effective dosage for the inhibition of gastric secretion varies greatly from one patient to the next. Thus, it cannot be administered according to body weight or in any recommended uniform dose. Dosage should be tailored to the patient's tolerance.

In peptic ulcer, the average adult dose ranges from 100 to 250 mg. three or four times daily.

'Elorine Chloride' is available in pulvules of 50 and 100 mg. at pharmacies everywhere.

Achieving added sedative effect

For anticholinergic action plus a quieting effect, prescribe 'Co-Elorine' (Tricyclamol Chloride and Amobarbital, Lilly).

Pulvules 'Co-Elorine' 25 contain 25 mg. 'Elorine Chloride' and 8 mg. 'Amytal' (Amobarbital, Lilly).

Pulvules 'Co-Elorine' 100 contain 100 mg. 'Elorine Chloride' and 16 mg. 'Amytal.'

1. Sun, D. C. H., and Shay, H.: A.M.A. Arch. Int. Med., 97:442, 1956.

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'CORTISPORIN'

For infected, or potentially infected, inflammatory conditions of the eye (anterior segment), ear and skin

VIRTUALLY NON-SENSITIZING

'CORTISPORIN' brand OINTMENT

Each Gm. contains: 'Aerosporin'® Sulfate Polymyxin B Sulfate 5,000 Units; Bacitracin 400 Units; Neomycin Sulfate 5 mg.; Hydrocortisone (free alcohol) 10 mg. (1%).

Available in applicator tip tubes of ½ oz. and ½ oz.

'CORTISPORIN' brand OTIC DROPS

Each cc. contains: 'Aerosporin'® Sulfate Polymyxin B Sulfate 10,000 Units; Neomycin Sulfate 5 mg.; Hydrocortisone (free alcohol) 10 mg. (1%). Available in sterile dropper bottles of 5 cc.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

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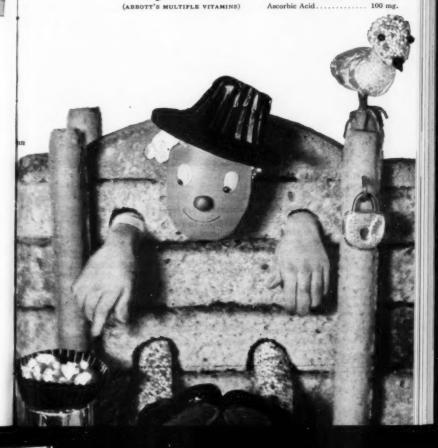
Between-Meal Claude is a Vitamin Fraud

His offense—incessant nibbling—may be a small one, but it can land him in <u>big</u> trouble. At dinnertime he's so full of snacks he couldn't eat a balanced meal if his health depended on it—as soon it will. When you bail him out with a decent new dietary, keep Dayalets in mind for potent multi-vitamin support. Ten important vitamins in each tiny tablet.

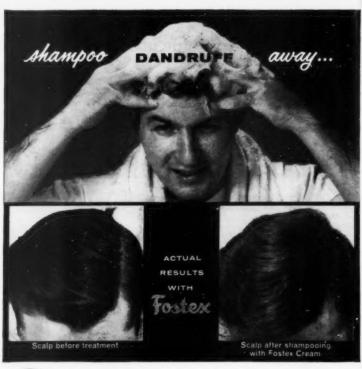
Obbott Dayalets°

10 important vitamins in each tiny Dayalet:

Vitamin A 3 mg. (10,000 units)
Vitamin D 25 mcg. (1000 units)
Thiamine Mononitrate 5 mg.
Riboflavin 5 mg.
Nicotinamide 25 mg.
Pyridoxine Hydrochloride 2 mg.
Vitamin B ₁₂ 2 mcg. (as cobalamin concentrate)
Folic Acid 0.25 mg.
Calcium Pantothenate 5 mg.



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new, effective, easy to use treatment for seborrhea capitis

Fostex Cream is a therapeutic shampoo to rid the "itchy" scaly scalp of dandruff . . . excess oiliness . . . seborrheic dermatitis. Fostex is effective and well tolerated. It does not contain selenium. And . . . the Fostex routine is easy . . . all the patient does is stop using his regular shampoo and start washing his hair and scalp with Fostex Cream. It's a treatment and shampoo all in one.

tolytic and antibacterial action, enhanced by sulfur 2%, salicylic acid 2% and hexachlorophene 1%.



Supplied in 4.5 ozr jars

Write for samples Fostex effectiveness in seborrhea capitis is provided by Sebulytic® and literature. (sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate), a new combination of surface active cleansing and wetting agents with remarkable antiseborrheic, kera-

Fostex Cream is also used for therapeutic washing of the skin in acne.

Westwood PHARMACEUTICALS

Division of Foster-Milburn Co., 466 Dewitt St., Buffale 13, N.Y.

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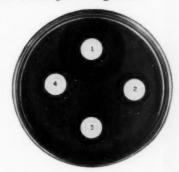
New Weapon Against Staphylococci

New soap germicide proved more effective than hexachlorophene against staphylococci, other skin pathogens.

 Today's new kind of Lifebuoy soap contains an important new advance in soap germicides. This soap germicide, even more effective than widely-publicized hexachlorophene, is tetra-methyl-thiuram-disulfide-usually abbreviated to TMTD.

Independent laboratory tests have shown that 1% TMTD-Lifebuov is considerably more effective than 2% hexachlorophene soap in reducing resident skin bacteria, comprised principally of staphylococci. Further testing proves TMTD-Lifebuoy extremely effective against a wide range of other skin pathogens relatively unaffected by hexachlorophene.

For a full report on the medical significance of TMTD-Lifebuoy, and a free full-size sample cake. mail in the coupon below.



Staphylococci. A comparison of 3 germicidal soaps and a control soap in inhibiting growth of Micrococcus pyogenes var. aureus on a nutrient agar plate. 1. 1% TMTD-Lifebuoy -large marked zone of inhibition. 2. 2% hexachlorophene soap-little inhibitory effect. 3. 2% Bithionol soap-little inhibitory effect. 4. Control soap-no inhibitory effect.

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for natural acceptance of your prescribed contraceptive regimen • fulfills your patient's natural wish that her possessions reflect her femininity. Each Lanteen Exquiset contains: 3 oz. tube of Lanteen spermicidal jelly, soothing, cleanly scented; easy-to-insert, molded, flat spring diaphragm; newly designed Easy-Clean applicator; universal inserter — all fitted into a stylish, soft plastic purse.

Lanteen Jelly contains ricinoleic acid 0.50%, hexylresorcinol 0.10%, chlorothymol 0.0077%, sodium benzoale and glycerin in a tragecenth base. Lanteen Jelly and flat-spring disphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N.Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada.) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, III. **TRADEMARK OF GEORGE A. BREON & COMPANY

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NTRODUCING

An important advance in menopausal therapy

■Because it replaces half control with full control.

■ Because it treats the whole menopausal syndrome.

■ Because one prescription manages both the psychic and somatic symptoms.

SUPPLIED: Bottles of 60 tablets. Each tablet contains:

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

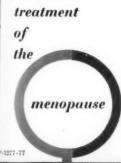
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A Proven Tranquilizer + A Pro

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WALLACE LABORATORIES, New Brunswick, N. J. who discovered and introduced Miltown, the original meprobamate.



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Vioform -Hydrocortisone **Cream** in this skin disorder, and many more

BEFORE



In just 7 days, clearing of SOAP-AND-WATER ECZEMA

AFTER



Supplied: Vioform-Hydrocortisone Cream, containing iodochlorhydroxyquin U.S.P. 3% and hydrocortisone (free alcohol) U.S.P. 1% in a water-washable base; tubes of 5 and 20 Gm.

SUMMIT, N. J.

VIOFORM® (iodochlorhydroxyquin U.S.P. CIBA)

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CIBA

why 50 million fathers have been happier than kings

Through the ages, even royalty was often helpless where problems of infant feeding were concerned. Crowns quivered as the hungry cries echoed through the palace corridors. Thrones trembled as the wails of the princeling wavered, grew weaker. And there was no answer.

Through the years medical science worked on the problems of digestive disturbances in infants. Progress was gradually made, and then in 1929 medical research demonstrated that evaporated milk offered one of the most versatile and satisfactory solutions to bottle feeding problems.

Since then, the fathers of more than 50 million babies have been happier than kings.

Unique in its combination of advantages, evaporated milk supplies maximum nourishment... plus a level of protein sufficient to duplicate the growth effect of human milk... flexibility in carbohydrate adjustment...easy digestibility... dependable sterility...

and all this at minimum cost.

PET EVAPORATED MILK ... backed by 72 years of experience and continuing research





PET MILK COMPANY . ARCADE BUILDING . ST. LOUIS 1, MO.

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For weight watchers... new low-calorie D-ZERTA GELATIN



Made without sugar*
12 calories
to a serving

There's nothing like a sweet dessert to keep up a weight watcher's spirits, so you will want to tell your diet patients about D-Zerta.

D-ZERTA GELATIN comes in 6 delicious flavors...D-ZERTA PUDDING (only 54 calories a serving) in 3 flavors—Vanilla, Chocolate and Butterscotch.

*Deliciously sweetened with Sucaryl® (Abbott) and saccharin. D-Zerta and Jell-O are registered trademarks of General Foods.

Made by the makers of Jell-O desserts for those who should watch their sugar intake.

For free copies of "Treats for Dieters" write to: General Foods Medical Dept., Box 5775-D, St. Paul, Minn.



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The Anesthetic

RECTAL MEDICONE®

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Either form of RECTAL MEDICONE affords the same recognized therapeutic benefits in the treatment of hemorrhoids and anorectal distress.



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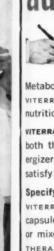
"DOCTOR, have you tried new Carnation Instant?"

YOU'LL DISCOVER WHY THIS EXCLUSIVE CRYSTAL FORM OF NONFAT MILK HELPS YOUR PATIENTS "STAY WITH" A DIET...IT TASTES SO GOOD!



These remarkable crystals burst into fresh flavor nonfat milk instantly, even in ice-cold water. Ready to drink. Enjoyed with and between meals, Carnation Instant helps allay fatigue and hunger. Extra crystals (1 tablespoon per glass, ½ cup per quart) may be added for flavor far richer than bottled nonfat milk-and 25% more nonfat milk nutrients. Patients who resist ordinary nonfat milk enjoy self-enriched Carnation Instant.

WHY NOT try new Carnation Instant yourself? A fine, protective "boost" for the busy physician. Ready instantly, fits into your most crowded professional day.





first...treat the

primary disorder,



of course **_**

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Metabolic stress hitchhikes along with every primary disorder. By simply adding VITERRA early in treatment, you combat stress by providing a comprehensive nutritional buildup program.

VITERRA is not just a vitamin, but a complete nutritional replenishment. Supplies both the 10 essential vitamins and 11 important minerals, the "metabolic energizers" which are a key to enzyme action. Together, vitamins and minerals satisfy tissue hunger and help speed recovery.

Specify the VITERRA form which best suits your—and your patient's needs. (1) VITERRA Capsules, for daily supplementation. In bottles of 30 and 100. (2) When capsules are a problem, VITERRA TASTITABS, which can be chewed, swallowed, or mixed in liquids. Ideal for children. In bottles of 100 and 250. (3) VITERRA THERAPEUTIC, when high potencies are indicated. In bottles of 30 and 100.

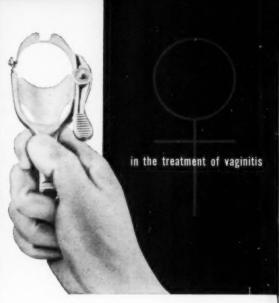
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MEDICAL ECONOMICS · JULY 1957 73





new...simple...effective...topical therapy

Clinical evidence shows Sterisil Vaginal Gel to be highly effective not only against Trichomonas and Monilia, but against the newly discovered pathogen Hemophilus vaginalis (now believed to be the etiologic organism most frequently responsible for so-called "non-specific" vaginitis and leukorrhea).*

High tissue affinity of Sterisil assures prolonged antiseptic action; vaginal secretions are less likely to remove Sterisil from the site of application. Sterisil is also more convenient for the patient. Fewer applications are required for successful treatment.

Acceptable to patients, Sterisil Vaginal Gel is easily applied, won't leak or stain, requires no pad. Signs of local or systemic toxicity or sensitization have not been reported.

Dosage: One application every other night until a total of 6 has been reached. This treatment may be repeated if necessary.

Supplied in 1½ oz. tube with 6 disposable applicators. Instructions for use are included with each package.

*Gardner, H. L., and Dukes, C. D.: Am. J. Obst. & Gynec. 69:962 (May) 1955.

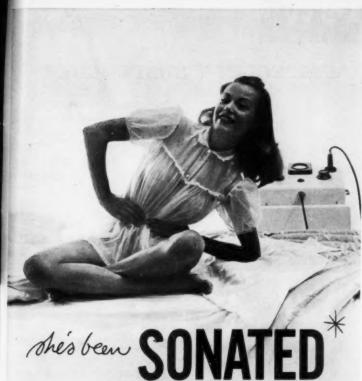
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*Yesterday she suffered from severe low back pain. Today, thanks to her physician's use of ultrasonic therapy, she's in the pink again.

Evidence on the value of ultrasonic therapy is growing daily in papers being presented by researchers and practicing physicians. These reports cover the treatment of conditions ranging from arthritis and bursitis to sinusitis and Herpes zoster. A large collection of medical journal reprints on ultrasonics, including valuable treatment and case history data; is yours for the asking.

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MYSTECLIN-V SUSPENSION

A delicious cherry-flavored oil suspension containing tetracycline phosphate complex equivalent to 125 mg. tetracycline hydrochlorid and 125,000 units Mycostatin, per 5 cc. teaspoonful. Two-ounce bottles

the logical combination for antibacter lera

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Squibb Tetracycline Phosphate Complex (Sumycin) + Nystatin (Mycostatin)

Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline hydrochloride and 250,000 units Mycostatin.
Minimum adult dosage: 1 capsule q.i.d. Bottles of 16 and 100.

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Sumycin Capsules (tetracycline phosphate complex equivalent to 250 mg. tetracycline hydrochloride): Bottles of 16 and 100.

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g. 00 the phosphate complex of tetracycline for initial antibiotic blood levels...faster and higher than ever before

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antifungal activity of Mycostatin for added protection against monilial superinfection

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WHY SHOULD YOU PRESCRIBE IT?
Because it provides highly effective broad spectrum antibiotic therapy for many common infections and at the same time protects your patients against the monilial overgrowth so commonly observed during therapy with the usual broad spectrum antibiotics

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Mild, yet positive in action, Noludar 'Roche' is especially suited for the tense patient who needs to relax and remain clear-headed— or for the insomniac who wants a refreshing night's sleep without hangover. Not a barbiturate, not habit-forming. Tablets, 50 and 200 mg; elixir, 50 mg per teasp.

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Noludar® brand of methyprylon (3,3-diethyl-5-methyl-2,4-piperidinedione)

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Tablets and Extentabs

Your obese patients may resist weight reduction because they fear losing the emotional security involved in overeating. AMBARTH Tablets or Extentabs® add incentive to weight reduction, give the patient a better chance of holding off the disabling effects of continued overweight and obesity. Methamphetamine, a more potent CNS augmenter than amphetamine yet producing less cardiovascular effect, is combined with phenobarbital result, mood amelioration without undesired excitation - weight reduction without jitters.

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10 to 12 hours of appetite suppression in 1 controlled-release, extended action tablet Methamphetamine

Hydrochloride . 10.0 mg. Phenobarbital (1 gr.) . . 64.8 mg.

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Hydrochloride . Phenobarbital (1/2 gr.) 21.6 mg.

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hemorrhoidal SUPPOSITORIES

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- soothe
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(by means of Norwegian cod liver oil, rich in vitamins $A \ \& D$ and unsaturated fatty acids)

Contain no styptics, local anesthetics, or narcotics and therefore do not mask serious rectal disease. In boxes of 12.





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The subway is taking him home today. But, sometime soon, the depression and anxiety you can see may lead him to irresponsible behavior, impaired mental and emotional health, or even to physical illness.

If he comes to your office, you'll find that Dexamyl* can help you to relieve his depressed sense of "being unable to do anything right." 'Dexamyl' is smooth and subtle in action, helps to restore a sense of well-being. In three dosage forms: tablets, elixir, Spansule†capsules.

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TAMPAX

a clinically accepted method of menstrual hygiene

WESTERN SURGER OBSTETRI GYNECOL

"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

AMERICAN JOURNAL OF ORSTETRICS AND GINECOLOGY

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

THE JOURNAL

Clinical

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"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

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"Easy and comfortable to use and eliminated odor."

Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

Three absorbencies: Junior, Regular, or Super Tampax meet varying requirements.

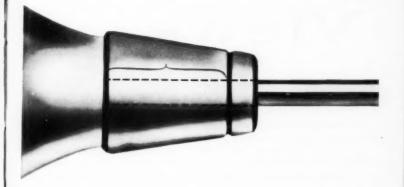


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What's so special about a B-D Needle?

double-length swaging





In the B-D Needle, swaging of hub and cannula extends over twice the usual length. Distribution of gripping pressure over a wider area produces a more secure bond without weakening or pinching the cannula. The result'is a stronger needle, a more dependable needle, and one with an unconstricted bore.

other "special" features of the B-D Needle:

side-bevel point gently and easily penetrates tissue... minimizes pain and prevents seepage.

Hyperchrome® stainless steel cannula is specially tempered to take a keener edge...hold it longer without resharpening. funnel-shaped juncture of cannula eliminates sharp shoulder where ordinary needles most often break. unique hub design simplifies cleaning... assures perfect fit.

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MEDICAL ECONOMICS · JULY 1957 83

Views

Most Damaging Charge

It's by all odds the most damaging charge that can be leveled against the medical profession. Yet you hear it almost every day:

"Because they can't pay for it, hundreds of people around here have to go without needed medical care."

Loose talk? Unfounded rumor? Maybe it is. But doctors will never spike it until they *prove* it's untrue.

A few years ago MEDICAL ECONOMICS told the story of how physicians in one area gave such proof. That was in Alemeda County, Calif., where close to 1,000 physicians made a public guarantee: No one in Alameda County need ever suffer without medical care through inability to pay.

To assure that the guarantee became known to everybody, the M.D.s staged a major advertising campaign ("THE PHYSICIANS OF THIS COUNTY UNCONDITIONALLY GUARANTEE MEDICAL CARE TO EVERYONE..."). It was a success.

And because the guarantee still stands—and is still publicized reckless rumors are pretty scarce in Alameda County today.

That's not always true elsewhere. Take Honolulu County, Hawaii. The doctors of Honolulu have had a similar guarantee for about three years. In the beginning they didn't say much about it. They just lived up to it.

Then one day a Honolulu disk jockey made the familiar charges over the air. At this the doctors sprang into public action. A medical representative appeared on the disk jockey's program the next morning and challenged him—or anyone else—to name one person in Honolulu who had been denied medical care. The jockey couldn't. He had to make a public retraction.

Nor did the doctors let it rest there. Since the radio incident, some two years ago, medical speakers at P.T.A. meetings, community associations, and women's clubs have broadcast the guarantee far and wide. How two y How medic How could 3,000

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How many requests for free care have come in as a result of these two years of publicity? About ten. How many more such attacks on medicine have there been? Zero. How many counties in the U.S. could profit by this story? About 3,000. Probably including yours.

You and Blue Shield

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Once there was a sorcerer's apprentice. He didn't have much stomach for such mundane tasks as carrying water into the house. But the water had to be carried. So the apprentice found an old broomstick, said a magic spell over it, and set it to work carrying water. He went back to his sorcery lessons.

A few hours later, he looked up to see water pouring through his doorway. The water tank was full to overflowing, and his broomstick creation was bringing up more buckets. When he tried to undo the spell, he found he couldn't. He got flooded right out.

What does this version of Paul

Dukas' symphonic poem have to do with you and Blue Shield? Well, the plain truth is that medicine could be the sorcerer's apprentice and Blue Shield the selfwilled broomstick—unless doctors recognize the danger and do something to avert it.

Iowa doctors are among those who have recognized and resolved the problem. Here's the story, as told by Dr. Richard F. Birge, secretary of the Iowa State Medical Society:

The Iowa State Medical Society founded Iowa Blue Shield. But having founded it, the doctors more or less abandoned the baby. There was little communication from either side. And because of this "lack of vigilance by organized medicine," says Dr. Birge, Blue Shield gradually got to the point where it "was not meeting the needs of physicians in nonsurgical fields ... was beginning to lose business ... was too inflexible ... to permit participation in certain new opportunities."

Last year the situation came to a head. Alarmed at the way Blue Shield and medicine seemed to be drifting apart, Iowa medical leaders rapidly took steps to bring them back together.

First they appointed a study committee. Then they set up a temporary liaison committee. Finally they arranged with Blue Shield to put three representatives of organized medicine permanently on the Blue Shield Board, ex officio. Blue Shield, in turn, was to place two of its officers on the Executive Council of the medical society. Communication was reestablished.

One of the first changes that resulted was the transfer of responsibility for setting up fee schedules from Blue Shield itself to the parent medical society. Iowa doctors have thus re-established the "prerogative of setting their own fees," Dr. Birge reports. And today, he adds, the doctors have "a beautiful working relationship with Blue Shield."

The most significant part of the Iowa story is not what did happen but what might have happened. When the Iowa study committee sat down to study Blue Shield, they found that Blue Shield was legally authorized to become their worst competitor. Its articles of incorporation authorized the plan to provide medical services directly to subscribers.

What might this mean? Dr. Birge puts it this way: "If participating physicians become recalcitrant. might not a Blue Shield board of the future decide to hire its own physicians to provide medical services?"

This exact threat may not exist in your state. But in many states, as Dr. Birge notes, Blue Shield has tended to become "aloof [from] changing conditions of medical practice and . . . insensitive to the needs of practitioners . . . "

Could this happen in your area? The answer seems to be "Yes, unless . . ." Yes, unless doctors keep in close touch with Blue Shield. Yes, unless doctors check the water supply before the flood begins.

Who Pays for Oldsters?

Today's biggest medical problem, says Dr. David B. Allman, the new president of the A.M.A., is how to provide care for people over 65. "We doctors are largely responsible for so many people living to be over 65," he points out; "now it's up to us to help see that these folks get good medical care." And though Dr. Allman doesn't say so, that means helping to see that they're able to afford it.

Health insurance helps most other Americans afford good medical care. Until a few years ago, a subscriber generally lost his health insurance coverage at 65-just Be

Rauwiloid

A Better Antihypertensive

. . . because among all Rauwolfia preparations Rauwiloid (alseroxylon) is maximally effective and maximally safe ... because least dosage adjustment is necessary . . . because the incidence of depression is less . . . because up to 80% of patients with mild labile hypertension and many with more severe forms respond to Rauwiloid alone.

A Better Tranquilizer, too

. . . because Rauwiloid's nonsoporific sedative action relieves anxiety in a long list of unrelated diseases not necessarily associated with hypertension . . . without masking of symptoms . . . without impairing intellectual or psychomotor efficiency.

> Dosage: Simply two 2 mg. tablets at bedtime. After full effect one tablet suffices.

Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating, making smaller dosage effective and freer from side actions.

Rauwiloid + Veriloid®

In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid and 3 mg.

Veriloid. Initial dose, 1 tablet t.i.d., p.c. Rauwiloid +

Hexamethonium

In severe, otherwise intractable hypertension this single-tablet combination provides smoother. less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, 1/2 tablet q.i.d.

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when he needed it most. Today, at least two ways are opening up for the man over 65 to keep his medical insurance:

1. Some 35 per cent of the big group health plans now permit the retired worker to stay in the group indefinitely.

2. Most Blue Shield plans (and an increasing number of private companies) now allow him to exchange his group coverage for an individual contract. And a good half of the major health insurance companies will now keep existing individual contracts in force (sometimes with reduced benefits) up to any age. Some will even write new policies for people as old as 85.

Unfortunately, this doesn't solve the problem. Being offered health insurance isn't the same thing as being able to afford it. And most oldsters can't.

Recognizing this, medical and insurance leaders have started proposing solutions. Doctors should be especially interested in two of them -both designed to give oldsters the cash they need to pay health insurance premiums.

The more striking of the plans has been drawn up by physicians themselves: the members of the Commission on Geriatrics of the Pennsylvania State medical society. In a nuts hell, the Pennsylvania plan would give oldsters their

3 when dermatoses are in bloom

NEO-MAGNACORT

topical ointment

NEOMYCIN + the first water-soluble dermatologic corticoid

outstanding availability, penetration, therapeutic concentrations and potency - without systemic involvement, In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% ethamicort (MAGNACORT).

for inflammation without infection MAGNACORT topical ointment

In 1/2-oz, and 1/6-oz, tubes, 0.5% ethamicort (hydrocortisone ethamate hydrochloride).

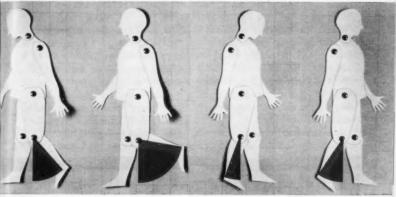


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Effective muscle relaxation for your patients with rheumatic, neurologic and similar conditions

atient, male, age 40, spastic diplegia; physiotherapy and massage previously ineffective. Then Tolseram was administered, the following improvement was seen within a month:



left knee, active: from 42° range to 80° range (nearly 100% increase)

right knee, active: from 20° range to 34° range (70% increase)°

* FROM ENGLER, M. : J. MENT. SCI. 101:391 (APRIL) 1991

TOLSERAM

Squibb Mephenesin Carbamate

Tolseram Tablets, 0.5 Gm., bottles of 100, 1000; Tolseram Suspension, 1.0 Gm. per 5 cc. tsp., pints and gallons. Adult dosage: 4 to 6 Tablets or 2 to 3 tsp. Suspension 3 to 5 times daily.

Also available:

Tolserol (Squibb Mephenesin) Tablets, 0.25 Gm. and 0.5 Gm., bottles of 100, 1000; Elixir, 0.5 Gm, per 5 cc. tsp., pints and gallons; Solution, 20 mg, per cc., 50 and 100 cc. ampuls. Tolserol with Codeine Tablets (0.5 Gm. Tolserol with $\frac{1}{2}$ gr. codeine), bottles of 100, 1000.

SQUIBB



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premium money through the Social Security system.

Added to the present 4½-percent Social Security tax would be an optional 1 per cent extra—half to be paid by the employer, half by the employe. Over a man's full working career, the Pennsylvanians estimate, a fund of something like \$3,000 would be built up.

When the employe turned 65, this money would be made available to pay his health insurance premiums, his additional doctor bills, and the cost of regular medical check-ups. If he died before using up the money, what was left would revert to his estate.

The second proposal worth

thinking about has been made by John H. Miller, a leader in the health insurance industry. His plan is similar to the Pennsylvania plan, but it rules out Government participation. Basically, the idea is to build up a man's post-retirement purchasing power by means of extra premium charges before he retires.

Beyond the current premiums, "the individual, or his employer, or both jointly" would chip in to a special fund "to be used for purchasing insurance for the cost of medical care for the post-retirement years." Such a plan would be administered by individual employers, as Mr. Miller envisions it.

for Nausea and Vomiting

ALWAYS

EMETROL

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(Phosphorated Carbohydrate Solution)

Highly effective when condition is functional; will not mask organic derangement; safe physiologic action...no drug side effects

- proved in: epidemic vomiting, functional nausea children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases.
- proved in: "morning sickness" 1 or 2 thsp. on arising; repeat in three hours and whenever nausea threatens.

In bottles of 3 fl.oz. and 16 fl.oz. DO NOT BELUTE



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Both these plans have considerable weight behind them. Both also introduce serious problems.

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But, as Drs. Joseph Freeman and Frank Rosenberry, authors of the Pennsylvania plan, rightly note: *Some* kind of plan to help the nation's oldsters pay for health insurance is urgently needed. Those who don't care for the plans mentioned here would do well to suggest alternatives. And they'd be well advised to do it soon.

Tongue Therapy

Two residents in a western hospital were talking about the most important tool in a doctor's armamentarium. "Clearly the antibiotics," said the first man.

"Maybe," said the second man.
"But radiologicals will head the armamentarium of the future."

At this point they were interrupted by the third man in the staff room, one of the distinguished physicians of the state. "You're both wrong," he said. "The most important tool in a doctor's armamentarium is his own tongue. What a doctor uses most in his daily work is language. And to practice more effective medicine, he needs to learn more linguistic skill."

There's nothing really new about this idea. But it has too little cur-

CLINICAL REPORT:

gas, bloating, heartburn seemed to "melt away" as soon as they swallowed

Coactyni

new systemic antispasmodic with a pH-adjusted vehicle for immediate topical relief to the spastic gut

Each tsp. contains 0.5 mg, homatropine methylbromide and 8 mg, phenobarbital in pH-adjusted phosphorated carbohydrate solution. Dose: 1 or 2 tsp., undiluted; particularly effective on empty stomach, 15 minutes before meals. In bottles of 3 fl.oz. and 16 fl.oz.



COLUMBUS, INDIANA

even articulate ones. Dr. C. B.

Lechner, retiring president of the Erie County (Pa.) Medical Society, recently developed it in a way that deserves to be repeated:

A patient complains of pain in his chest, so you question him:

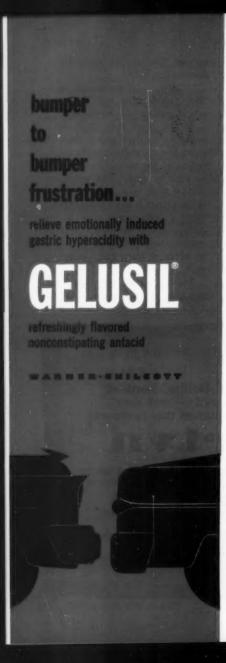
"Does it hurt when you breathe deeply?" Diagnosis may depend on your follow-up questions—on how well you get him to communicate the kind of hurt. All the auscultation in the world won't replace this linguistic skill.

Or the patient may tell you that he's had "some pretty bad heartburn." What does he mean? As Dr. Lechner suggests, it takes precise questioning to find out.

Words probably count most in prognosis. Says Dr. Lechner:

"When Granddad has had a stroke and lies on his back, struck dumb, with one side unable to move, it makes a difference what the doctor says to his family. Take the doctor who says, 'We have done everything for Granddad that can possibly be done, and we'll watch for chances to do more as we observe the course of the illness.' He does a better job for medicine and mankind than the less thoughtful chooser of words who thinks he says the same thing in this sentence: 'Nothing more can be done for Granddad."

What's the major difference between an M.D. and a veterinarian? Words, words, words. It pays to become proficient in their use. END





Shrinks the Appetite

Curbs excessive desire for food Helps to ease bulk hunger Reduces nervous tension hunger

once, twice or three times daily. The usual dosage is one tablet upon arising and at 11 A. M. and at 4 P. M.

Supplied: Bottles of 100 and 1,000 tablets

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NEW INTRAMUSCULAR IRON PROVIDES

PRECISION THERAPY, PROMPT RESPONSE

IMFERON,® the new intramuscular iron-dextran complex, was introduced to American hematologists at the Sixth International Congress of the International Society of Hematology held in Boston, August 27 to September 1, 1956. Recent experience from over 6 million injections has shown that this iron preparation is easy to administer, notably free from toxic effects, quickly absorbed and productive of rapid hematologic and clinical improvement. It has been termed "...the only therapeutically effective iron preparation for intramuscular use..."

IMFERON meets the need for a safe, effective agent when parenteral iron is preferable for patients with iron deficiency anemia who are resistant or intolerant to oral iron, those with depleted iron reserves and those who require rapid restoration of hemoglobin, e.g., last trimester of pregnancy. Previous parenteral iron preparations were unsatisfactory because of toxicity. pain on injection, or because they contained insufficient iron. IMFERON contains the equivalent of 5 per cent elemental iron. It is more stable than iron saccharate both in vitro and in vivo and does not precipitate in plasma over a wide pH range. It is isotonic with tissue fluids and has a pH of 5.2 to 6.0.1 Utilization for hemoglobin formation is almost quantitative.

Precision Therapy with IMFERON: Before treating a patient with IMFERON, total iron requirement is calculated by formula or determined from a convenient dosage chart. Then appropriate amounts of IMFERON are injected daily or every other day, until the total calculated required amount is given.

Iron Deficiency Anemia of Infancy: IMFERON provides a convenient, safe means for restoring hemoglobin levels and iron reserves in anemic infants. Excellent results were obtained by Gaisford and Jennison² with IMFERON in 100 iron-deficient infants. From a pretreatment average of 54.5 per cent, hemoglobin levels rose to 87 per cent 10 weeks after the start of therapy.

Clinical improvement paralleled this response. Premature infants and surgical cases were similarly benefited. IMFERON gave "...all the advantages of transfusion or intravenous therapy without the disadvantages."2 There were no side effects in any of the infants treated. Wallerstein^a confirmed these results, furnishing evidence that IMFERON is well absorbed and appears in the bone marrow 12 to 24 hours after injection. Results are equal to those with intravenous saccharated iron oxide without the unpleasant side effects. Sturgeon4 showed that the first year's iron requirements in infancy can be supplied with three injections of IMFERON.

Iron Deficiency Anemia of Pregnancy: Nausea precludes oral iron therapy in many anemic pregnant women. In those with severe anemia who are first seen late in pregnancy, prompt hemoglobin regeneration is unobtainable with oral iron. IMFERON produced prompt hemoglobin responses in anemia of preg-

nancy,5 those o charate virtual Resist Patient iron, th and the ogy re IMFER little v rheuma benefi easier ' Present recent confirm of IMF tion ar than 7 pleted stress ease o from s additio Brochu side L Wiscon

> (1) Brov tins, L. York, G p. 25. (Brit. M. stein. (4) Stu (5) Jenr 2:1245 Govan. 1954. (A.M.A. (8) Mill Rheuma and Poo 1954. (1 Hendry, 2:1255 A.M.A. A

INFERON® INC., UND ITED. AVA nancy,^{3.6} the results being similar to those obtained with intravenous saccharated iron oxide. Side effects were virtually absent with IMFERON.^{3.6}

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Resistant Hypochromic Anemia: Patients who do not respond to oral iron, those who cannot take oral iron and those with gastrointestinal pathology respond well to injections of IMFERON.⁷⁻¹¹ While oral iron is of little value in treating the anemia of heumatoid arthritis, IMFERON is "...as beneficial as intravenous iron and easier to administer."

Present Studies: Published reports and recent findings of clinical investigators confirm the effectiveness and safety of IMFERON for hemoglobin regeneration and creation of iron stores. More than 70 studies are now being completed in the United States. Reports stress prompt hemoglobin response, ease of administration and freedom from side effects. Clinicians desiring additional information should request Brochure No. NDA 17, IMFERON, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

(1) Brown, E. B., and Moore, C. V., in Tocantins, L. M.: Progress in Hematology, New York, Grune & Stratton, Inc., 1956, vol. I, p. 25. (2) Gaisford, W., and Jennison, R. F.: Brit. M. J. 2:700 (Sept. 17) 1955. (3) Wallerstein, R. O.: J. Pediat. 49:173, 1956. (4) Sturgeon, P.: Pediatrics 18:267, 1956. (5) Jennison, R. F., and Ellis, H. R.: Lancet 2:1245 (Dec. 18) 1954. (6) Scott, J. M., and Govan, A. D. T.: Brit. M. J. 2:1257 (Nov. 27) 1954. (7) Grunberg, A., and Blair, J. L.: A.M.A. Arch. Int. Med. 96:731, 1955. (8) Millard, J. B., and Barber, H. S.: Ann. Rheumat. Dis. 15:51, 1956. (9) Baird, I. M., and Podmore, D. A.: Lancet 2:942 (Nov. 6) 1954. (10) Cappell, D. F.; Hutchinson, H. E.; Hendry, E. B., and Conway, H.: Brit. M. J. 2:1255 (Nov. 27) 1954. (11) Stevens, A. R.: A.M.A. Arch. Int. Med. 96:550, 1956.

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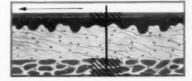
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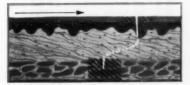
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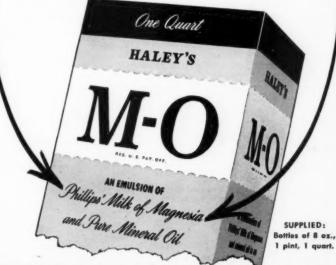


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uninterrupted antisecretory-antispasmodicsedative effect in peptic ulcer and visceral spasm



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- Eliminate the problem of frequent medicine taking. Your patients need remember only one dose in the morning or evening. With 'Spansule' capsules, forgotten or missed doses are a thing of the past.
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first in sustained release oral medication





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CALCINATAL

6 Tablets Provide:

Calcium Lactate	Niacin 15 mg. Ascorbic Acid 150 mg. Vitamin D 400 USP Units Vitamin B,—Activity* 5 mcg. Pyridoxine HCl 3 mg. Aluminum Hydroxide gel 750 mg.
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Orinase Prescription Information

Dosage: Patients responsive to Orinase may begin therapy as follows:

First day 3 Gm. Second day 2 Gm. Third day



Third day 1 Gm.
Usual maintenance dose 1 Gm.

(must be adjusted to patient's response)
To change from insulin to Orinase:
If previous insulin dosage was

less than

40 u./day . . . reduce insulin 30% to 50% immediately; gradually reduce insulin dose if response to Orinase is observed.

more than 40 u./day . . . reduce insulin 20% immediately; carefully reduce insulin beyond this point if response to Orinase is observed. In these patients, hospitalization should be considered during the transition period.

Caution: During the initial "test" period (not more than 5 to 7 days), the patient should test his urine for sugar and ketone bodies three times daily and report to his physician daily. For the first month, he should report at least once weekly for physical examination, blood sugar determination, and white cell count (with differential count, if indicated). After the first month, the patient should be seen at least once a month, and the above studies carried out. It is especially important that the patient, because of the simplicity and ease of administration of Orinase, does not develop a careless attitude ("cheating" on his diet, for example) which may result in serious consequences and failure of treatment.

Supplied: In 0.5 Gm. scored tablets, bottles of 50.

Complete literature available on request.



THE UPJOHN COMPANY KALAMAZOO, MICHIGAN



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Orinase prescrip before drug tations.

Indicate benefit betes is adequations a after the

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the new Oral antidiabetic agent ORINASE*

Used investigationally in more than 18,000 patients!

(Tolbutamide, Upjohn)

Ready for your prescription now. Orinase is now available in all leading prescription pharmacies. But please before you prescribe this exciting new drug—be sure you understand its limitations.

Indications. Orinase is most likely to benefit the patient in whom the diabetes is relatively mild and stable, is not adequately controlled by dietary restrictions alone, and developed sometime after the age of 30 years.

Contraindications. Orinase is contraindicated in patients with 1) diabetes of the type known variously as juvenile, growth-onset, unstable, or brittle; 2) a history of diabetic coma; 3) diabetes complicated by ketosis, acidosis, coma, fever, severe trauma, gangrene, Raynaud's disease, or serious impairment of renal or thyroid function; 4) hepatic dysfunction; and 5) diabetes adequately controlled by dietary restriction.

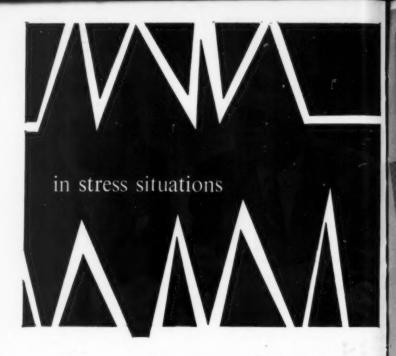
Effects. In patients with a satisfactory response to Orinase, the blood sugar falls, glycosuria diminishes, and such symptoms as pruritus, polyuria, and polyphagia disappear. It is not a substitute for insulin. And it requires the same adherence to basic principles of diabetes control as does insulin, e.g.,

dietary regulation; tests for glycosuria and ketonuria; hygiene; exercise; instruction of the patient to recognize and counteract impending hypoglycemia, to follow rigidly directions regarding diet and continuing use of the drug and to report immediately to the physician any feeling of illness. Extreme care must be taken during the transition period to avoid ketosis, acidosis, and coma.

Side effects. To date, the most serious side effect is hypoglycemia, which may occur occasionally and is most likely to occur during the transition period from insulin to Orinase. Other untoward reactions to Orinase are rare, usually of a non-serious nature, and tend to disappear on adjustment of dosage, e.g., gastrointestinal disturbances, headache, variable allergic skin manifestations, and alcohol intolerance.

Clinical toxicity. Aside from an occasional hypoglycemia, Orinase appears to be remarkably free of gross clinical toxicity. There is no evidence of crystalluria or other untoward effects on renal function, or of hepatotoxicity. Except for a rare leukopenia of mild degree, which has been reversible (in some instances, even under continued therapy), there have been no adverse effects on hematopoietic function.

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effectively supplements ataractic therapy



The modern tempo of life, as reflected in the stressful activities of the responsible executive, often induces physical and emotional debilitation. To meet increased metabolic needs caused by stress, STRESSCAPS promptly replenishes vitamins in an authoritatively recognized formulation.

Each Capsule Contains: Thiamine Mononitrate

10 mg. Riboflavin (B₂) 10 mg. Niacinamide 100 mg. 300 mg. Ascorbic Acid (C)

Pyridoxine HCl (Ba) 2 mg. Vitamin B₁₂ 4 mcgm. Folic Acid 1.5 mg. Calcium Pantothenate 20 mg. Vitamin K (Menadione)

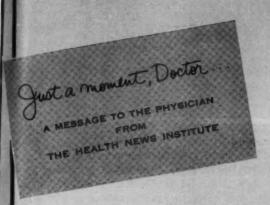
Average Dose: 1-2 capsules daily.

STRESSC

Stress Formula Vitamins Lederle



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THE MAGIC PIPELINE

The last Japanese plane had scarcely vanished into the Sunday morning sky on that fateful day of December 7, 1941, when the heart and hope of Pearl Harbor suddenly turned to sources of help the very existence of which, to many of those on the base, had been heretofore unknown.

The immediate need was for drugs and dressings—dressings to bind up burns and wounds; sulfas to sustain the thread of life in the gravely injured; narcotics to ease the agony of the dying; amphetamine sulphate for survivors whose rescue task was such that for the next 72 hours they could give no thought to sleep.

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2 mg. mcgm. .5 mg. 20 mg.

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What were these places — these arsenals of the rescue effort? The local wholesale drug houses.

And luckily, the managers had stocked their shelves with foresight. Their inventories were equal to the emergency. And when, after the first shock had been absorbed and supplies began to run out, re-orders going stateside for drugs and surgicals had the same priority as requisitions for guns and ammunition.

Yes, the wholesale drug house is a stockpile against disaster — and not alone in wartime, but in any kind of calamity, be it man-made or act of nature. But the wholesaler is also a great deal more. And the key role he plays on the health team is too little understood.

The wholesaler is vital to the logistics of distribution. He serves both manufacturer and pharmacist, making simpler the tasks of each, facilitating the flow of medicines and specialties so that they are immediately available. This means, of course, that his ultimate and most important service is the one he performs for your patient.

With this article we conclude our series of messages.

Now it's time to say "Thank You Doctor" for the moments you've given us out of your busy professional life. We know that many of you have, indeed, read these stories about the several elements of the pharmaceutical team because your letters have told us so.

In fact, your response has been so gratifying that we're thinking of putting the nine messages into a single package—re-edited, perhaps, for the layman. We are sure you would agree that your patients, too, should know the story of pharmaceutical research, should have a sensible and documented perspective on the price of prescriptions, should gain a better grasp of the dove-tailing importance of prescriptions and proprietaries, should comprehend the teamwork between physician, pharmacist, and purveyor, both at the manufacturing and distributing level.

Again, thank you for reading these messages, and thanks to the editors of MEDICAL ECONOMICS for contributing the pages on which to print them.

> Sincerely, CHET SHAW

The some 400 general line drug wholesalers operating in 180 cities comprise a nationwide distribution network, channeling the products of almost 2,000 manufacturers to 53,000 drug stores and 6,000 hospitals.

And they deliver the goods in record time — and not just in emergencies, either. For example, one order from a retail druggist involved 83 items from 68 suppliers in 35 cities in 20 states. Picture, if you can, the confusion and the log jam, the correspondence and the bookkeeping, if the pharmacy had ordered direct from the manufacturers. Think how much the wholesaler

helps the druggist, merely by the credit he extends.

Nor can any pharmacist possibly hope to stock all of the drugs and specialties which are now available to combat disease and pain. In fact, the average drug store has shelf space for only 2,000 of the 40,000 items which make the American reservoir of drug and related products the richest in the world.

The wholesale drug house backstops both the retail store and the hospital with a reserve of more than 12,000 pharmaceutical preparations alone. And it has the resources to obtain others on short notice. According to the American Druggist Blue Book, the general line wholesaler last year had access to 172,320 items produced by almost 7,000 manufacturers.

The service rendered by the wholesale druggist does more than reduce the physical problem of inventory and bookkeeping in the pharmacy. It also cuts down on the pharmacist's storekeeping chores, giving him those precious moments for personal relationships with the customer, time in which to answer questions that reassure, supplementing and fortifying your own professional advice.

The wholesaler does, indeed, preside over a magic pipeline.



THE HEALTH NEWS INSTITUTE
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THE PICTURE OF COMFORT AND THROUGH THE PREGNANCY

if she's blue at breakfast ...

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Prescriba: One tablet at bedtime. Severe cases, one tablet at bedtime, one on arting in tiny pink-and-blue tablets, buttles of 25 and 100. It only.

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Usually 3 tablets daily, with meals In bottles of 100.

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NOW...BREAK THE SHACKLES OF BRONCHOSPASM WITH

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Formula: (in the coating) 20 mg. racephedrine HCl, 27.5 mg. pentobarbital, (in the core) 200 mg. choline theophyllinate (Choledyl®).

Indications: Bronchospasm associated with or due to asthma, hay fever, emphysema, bronchitis, bronchiectasis, and to pulmonary infections in general.

Average dosage: Adults, 1 tablet every 3 to 4 hours. Children, 10 to 15 years of age, 1 tablet every 4 hours.

Supply: 100, 500 tablets

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The excellent clinical results obtained with Cholarace are based on the superiority of each of its three components. Choledyl is better tolerated than oral aminophylline. Racephedrine produces less CNS stimulation than ephedrine. Pentobarbital has faster and shorter action than phenobarbital.



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with stress supportive
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NASAL SPRAY prompt nasal comfort without jitters or rebound

ESPECIALLY FOR RESISTANT AND YEAR-ROUND ALLERGIES

Because edema is unlikely with the tablets and sympathomimetic effects are absent with the spray, METRETON Tablets and Nasal Spray afford enhanced antiallergic protection in vasomotor rhinitis and all hard-to-treat allergic disorders—even in the presence of cardiorenal and hepatic insufficiency.

COMPOSITION AND PACKAGING

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Each cc. of METRETON Nasal Spray contains 2 mg. (0.2%) prednisolone acetate and 3 mg. (0.3%) chlorprophenpyridamine gluconate in a nonirritating isotonic vehicle.

Plastic squeeze bottle of 15 cc.

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for the arthritis patient who is intolerant to ASPIRIN **ECOTRIN*** S.K.F.'s Duentrictcoated aspirin provides full aspirin effect without gastric upset

Smith, Kline & French Laboratories, Philadelphia

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JULY, 1957



An Investment Pattern For Today's Doctor

By Thomas Owens

A 45-year-old G.P. whom I'll call James A. Benson has just resolved one of life's major financial problems: He's decided on the investment program he'll follow in handling his accumulated savings of \$30,000, plus any future savings he accumulates.

Though he did a good deal of reading, thinking, and consulting before making his decision, the plan he finally arrived at is quite simple: He's going to put half his fund into tax-exempt bonds that will pay him a fixed

return every year. The remaining \$15,000 he'll invest in stocks through the medium of three closed-end investment trusts that aim at capital growth.

How He'll Hedge

As savings accumulate in future years, he'll continue to allocate half to stocks and half to bonds. But all investment earnings (bond interest as well as the return on his stocks) will go entirely into more stocks. Reason: The doctor wants to hedge against a continuation of the present inflationary trend by giving a bit more emphasis to stocks (whose value rises with inflation) than to bonds (whose real value declines during inflation).

How did Dr. Benson arrive at his investment plan? He analyzed his problem in logical fashion by jotting down a series of questions. They went about like this:

What to Invest In

 What kind of investment matches my investment goal?

Dr. Benson decided that his primary aim was growth of capital rather than current income. The best prospects for real growth, he felt, were in real estate or in stocks and bonds.

At first, he leaned toward the idea of investing in real estate. Land and buildings are such solid, tangible things. What's more, he knew two medical colleagues in town who had doubled their money in just a few years by some judicious real-estate investments.

Land's Too Specialized

But after more reflection and consultation, the doctor's initial enthusiasm waned a bit. Real estate, he realized, was a highly specialized kind of investment; it required time-consuming preliminary investigation, plus constant attention and management. Moreover, though the real-estate market was active at the time, property might be about the hardest kind of investment to liquidate in a recession.

That left securities—stocks and bonds—as the alternative. Once that became clear, the doctor made a further important decision: Though he wanted his capital to grow, he also wanted it to be reasonably safe. So he automatically eliminated from consideration such out-and-out speculations as "penny" uranium stocks, Canadian oil wells, and foreign mines.

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2. How much of my money should be in stocks, and how much in bonds?

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One booklet the doctor came across pinpointed the problem this way: "In times of inflation, a fixed-dollar investment (as in bonds) offers no protection against declining purchasing power. But a common stock investment tends to increase in value and thus offset the decline in purchasing power. During deflation, on the other hand, common stock prices fall and the bond investor is in a more favorable position."

Dr. Benson doubted his ability to predict whether the nation was headed for inflation or deflation in the years ahead. Few economists, he recalled, had successfully called the turn on previous changes in the economy. So it seemed wisest to hedge against the possibility of either inflation or deflation.

In hedging, he realized, an investor can't expect to be completely right with all his funds all the time. But by putting half into stocks and half into bonds, he can be completely right with half his funds all the time.

Into this line of reasoning Dr. Benson introduced his own refinement: Theoretically, he told himself, there seems to be an equal chance that any given period in the future might be one of



"How about 'Elvis'?"

either inflation or deflation. So a straight fifty-fifty division of funds would theoretically be ideal. But historically, the nation's long-term economic *trend* has been inflationary—at the rate of about 3 per cent a year for the past fifty years. So Dr. Benson decided to emphasize equities over the long pull by annually plowing back all investment earnings into stocks.

What Type of Bonds?

Granting that half his funds would be in bonds, what kind of bonds should he buy? Naturally, he thought first of U.S. Savings Bonds, safe as the Government itself and paying 3½ per cent. Then he remembered that they don't pay interest annually, but only at maturity. This wouldn't provide him with the regular returns he wanted for his over-all plan.

Next he considered corporation bonds, paying about 4½ per cent annually. He figured he'd lose too much of this annual interest in taxes, however.

Finally the doctor considered—and bought—tax-exempt municipal bonds. The annual interest (about 3 per cent) would be exempt from Federal tax. So

each year Dr. Benson would have the full amount of his bond interest available to invest in stocks, as he'd planned.

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After he'd thus settled his bond problems, the doctor began analyzing how to invest in stocks. He approached the problem by working from general questions down to specific ones:

3. Should I invest in stocks directly, or through an investment fund?

For a while, Dr. Benson favored the idea of investing directly in individual stocks that he would select himself. Then, in an article on investments, he read this pertinent paragraph:

"Successful investment requires constant application. You can't just buy a security and forget it; a company doing well this year may be in trouble next year. The prudent investor follows the financial page of a big city newspaper, reads at least two investment journals regularly, studies all the literature his companies send him."

He Didn't Have Time

The doctor reflected that since it was all he could do to keep up with his medical reading, he could hardly find time to take on The Wall Street Journal or The Commercial and Financial Chronicle.

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From that point on, he figured that he'd invest in stocks through the medium of an investment fund. This way his money would get professional management and the doctor would be relieved of all the details of security transactions.

Mutual or Closed-End?

4. Should I invest in a mutual fund, or in a closed-end fund?

Dr. Benson had no feelings one way or the other; he simply wanted to put his money where it would grow fastest.

At the public library, the doctor found several books on the subject. Most were impressive tomes full of charts and statistics. But one was a smaller, less formidable pamphlet.* Reading it over that evening, Dr. Benson found what he was looking for: a chapter comparing the growth record of open-end and closed-end funds.

After an exhaustive study of performance records, the authors had concluded: Closed-end com-

panies had a much better record of growth. An investment made in them before World War II would have grown by 1,172 per cent by 1956. A similar investment in the open-end mutual funds would have appreciated only 612 per cent in that same period.

That's when the doctor decided it would be closed-end trusts for him. His selection of the individual funds was relatively simple:

He carefully examined those with the best historical growth records and chose three: Carriers and General Corporation, Consolidated Investment Trust, and Tri-Continental Corporation. All of these are long-established trusts that have been especially well managed over the years.

How It Worked Out

How does Dr. Benson feel about his investment plan today, now that it's operating? Well, he realizes that it will never put him in line for a speculative killing. It's not geared for that. But he figures it should chalk up a creditable performance in terms of capital growth.

And so far it shows every sign of doing so. END

^{6&}quot;Investment Trusts and Funds," by C. Russell Doane and Edward J. Hills, published by the American Institute for Economic Research, Great Barrington, Mass.



Are You Talking our

1. Here's What You Might Say

"He sure left you in one hell of a mess, didn't he?"

The surgeon who made this half-humorous comment on a previous surgeon's handiwork obviously didn't expect the patient to take it seriously. But the patient did. In fact, he took it to his lawyer.

When sued for malpractice, the previous surgeon told the full story of what had happened. Then it was the second surgeon's turn to be "in one hell of a mess." His snap judgment, which had started the suit, was publicly exposed as being totally in error.

It seems the patient had a persistent fecal fistula. Surgeon No. 1 had carried out conservative therapy, then advised the patient that an operation would be necessary as soon as the inflammation had subsided. The patient had never returned.

After hearing these facts, the patient's family helped induce him to withdraw his suit. It should never have been filed in the first place. And it wouldn't have been, except for the second surgeon's casual remark.

That's the trouble with casual remarks: Patients take them far more seriously than doctors intend. The following real-life examples look brutal in print. They look like .

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ng our Colleagues Into Court?

By Stanley H. Macht, M.D.

obvious disparagement of another doctor's treatment an open invitation for the patient to file suit. Yet the doctors concerned made them lightly and probably never thought of the consequences:

¶ "Any M.D. should know you don't put warm water on a gangrenous leg." This comment by a doctor landed the previous attendant in court for a slight, understandable error—certainly not malpractice. The circumstances at first had pointed to frostbite, for which the previous doctor had prescribed proper care.

¶ "A third-year medical student could have made this diagnosis with ease." An internist said this about a case of vulvovaginitis associated with diabetes. The patient promptly sued her family physician, and he went through the ordeal of a long court case before being cleared.

¶"What cultist did that?" That's how one physician reacted to a garbled account of treatment apparently based on chiropractic theory. The "cultist" turned out to be a well-regarded orthopedist, against whom the patient immediately filed suit.

Most of us can truthfully say we've never made such remarks and never will. Yet such good intentions don't wholly eliminate the chance of putting a fellow doctor behind the eight-ball.

Recently a midwestern woman was asked what Doctor B had said that made her file suit against Doctor A. "He didn't have to say anything," she snapped. "He just whistled!"

A raised eyebrow, a puzzled frown, a shake of the head—any one of these at the wrong moment can apparently trigger a malpractice suit against a colleague. The word "apparently" is used because such things don't always show up in the statistical summaries of the causes of malpractice suits.

Hard to Pin Down

Actually, it's impossible to say exactly just what percentage of malpractice claims are caused by colleague criticism. A few authorities place it as low as 25 per cent. The majority opinion, however, is that it's higher.

A number of insurance company representatives have been asked to supply figures on cases resulting from doctors' remarks criticizing a colleague's treatment. Most of their answers tend to show why the percentage is in doubt. Typical is this reply from H. B. Hopkins of U. S. Fidelity & Guaranty: "It is difficult to determine the underlying cause for malpractice suits... I do not feel that criticism of one physician by another . . . is the cause of the majority of all malpractice suits."

Not on the Record

Adds E. W. Cochran of the Cochran Insurance Agency in Hagerstown, Md.: "From advices received from two large companies (Hartford Accident and Maryland Casualty) it would appear that if a malpractice claim originated from some statement made by a doctor . . . it has not gone on the records in that manner."

One of the few firm figures from insurance men is this one from Don C. Hawkins of St. Paul Mercury: "After many years' experience . . . working with national and state medical societies and hospital groups, it is my confirmed opinion that conservatively 75 per cent of all malpractice claims are brought about as the result of statements made by doctors to patients."

When the same question was asked of the grievance committees of state medical societies, more definite answers were rerepre from Fro

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From Montana, Dr. Park W. Willis Jr. reports that while their figures "have never been so analyzed," people in a position to know say "probably 95 per cent of all suits originate from the careless remark of a doctor regarding the treatment another doctor has given."

"The Vast Majority . . . "

From North Carolina, medical society counsel J. H. Anderson Jr. reports: "The vast majority of such suits arise as a result of unfortunate expressions of physicians themselves."

From New Mexico, Dr. Lewis M. Overton reports: "We feel that a great majority of the malpractice suits have been initiated by some remark made by a physician—even though it was done without any intention of causing problems."

From West Virginia, Dr. Walter E. Vest reports: "The great majority of them are instigated—or if not actually instigated, are brought to the mind of the patient—by indiscreet remarks on the part of some doctor."

From Nebraska, Dr. J. P. Gil-

ligan reports: "Fully 50 per cent of our suits and threatened suits are the result [of colleague criticism]."

From Kentucky, Dr. J. D. Gordinier reports that a study of twenty-five malpractice cases showed "seven were caused directly by an opinion expressed by a doctor as to former treatment of the patient. Five of these were careless statements which could as easily have gone unmade. Two of them arose from nothing less than pure malice."

From Rhode Island, Dr. Francis B. Sargent reports that only two cases in recent years resulted from colleague criticism. And he adds: "We have had no such trouble during the past two years as the result of a campaign of education."

1,000 Times a Year

Are you talking your colleagues into court? Probably not. But some doctors are. Across the country, it's happening between 500 and 1,000 times every year, at a conservative estimate. Which gives us all a stake in a campaign of education similar to Rhode Island's.

We could begin by following the example of one doctor I

TALKING COLLEAGUES INTO COURT?

know. Facing him on his desk is a framed copy of this quotation from Anacharsis:

"The tongue is, at the same

time, the best part of man and his worst; with good government none is more useful, and without it none is more mischievous."

2. Here's What You'd Better Say

By John E. Eichenlaub, M.D.

Now that you know what *not* to say to a patient about his prior treatment, there's still a problem remaining. You can't simply ignore his description of past prescriptions, operations, or other therapy. Particularly if he expresses dissatisfaction, you've got to say something positive.

What can you say that will be accurate enough and, at the same time, reassuring enough to avoid precipitating a suit against the former physician? I've been collecting ideas from experienced practitioners. In sum, they amount to this:

1. You can explain that people react differently to different forms of therapy. A well-known dermatologist once kicked off an unwarranted suit when he remarked: "That ointment was too strong for you." Ever since, when confronted with another doctor's poor result, he's carefully ex-

plained the skin's individual response to therapeutic measures.

"Imagine getting blisters from a few seconds under the ultraviolet light," he told a patient recently. "Of course, you're a redhead and your skin is very fair. But it must react at least ten times as strongly to ultraviolet as the usual fair skin does."

2. You can specifically exonerate the previous doctor when illness has left aftermaths. Patients often blame the normal after-effects of illness on the type of treatment they received. Old Mrs. Moore, who came to my partner with post-herpetic neuritis, was a good example.

"All I had was shingles," she told him. "But my daughter's city doctor got upset. 'Let's give her X-rays over the nerve roots,' he said. And ever since I've had this pain."

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Fastest-Growing Health Insurance Today

The doctor isn't bound by a fee schedule, and the patient pays part of all major bills, under the kind of policy the industry calls 'comprehensive'

By Hugh C. Sherwood

About four years ago, the insurance industry came up with a brand-new kind of health insurance that wraps both basic and major medical coverage into one big package. They called it "comprehensive" health insurance—or occasionally by names like "comprehensive major medical" or "basic major medical." Actually, "semi-comprehensive" would be a more accurate name.

This type of policy is not comprehensive in the sense that group practice prepayment plans are comprehensive. It does not spare the subscriber from virtually all med-

FASTEST-GROWING HEALTH INSURANCE

ical costs beyond his premiums. But it provides unusually broad coverage; it's selling unusually fast; and it combines a number of features that doctors have long talked about as being desirable:

¶ Like Blue Cross-Blue Shield, it covers the hospital, surgical, and medical services normally required during *short-term* illness in the hospital. But it goes fur-

ther: It covers home and office care, private-duty nursing, and prescriptions too.

¶ Like major medical expense insurance, it also covers most services required during long-term illness, up to liberal limits.

¶ Like automobile collision insurance, it's written on a *deductible* basis: Usually, before the patient can start getting benefits

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Some Key Facts About Semi-

What's the typical premium on a semi-comprehensive policy?

There is no typical premium. Such policies are tailor-made to fit particular companies; and premiums are based in part on the ages, incomes, and sex of the company's employes. Semi-comprehensive premiums run roughly the same as those for basic Blue Cross-Blue Shield *plus* major medical coverage.

Is the premium the only payment required of the insured toward the cost of his medical care?

No. Semi-comprehensive policies require insured persons to pay a deductible (usually \$25 or \$50) on the first part of their medical care. Once the deductible has been paid, such policies also require the patient to pay for a portion (usually 20 or 25 per cent) of the remainder of his care.

On what basis is the deductible applied?

Some policies require the insured to pay a new deductible for each new illness. But it's more common to have him pay only one deductible within a given expense period (usually one

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from his semi-comprehensive insurance, he must pay the first \$25 or \$50 of medical costs he incurs during the policy year.

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Like certain types of fire insurance, it employs the coinsurance principle: The patient is usually required to pay 20 or 25 per cent of his medical care costs during the policy year, over and above the deductible (which he is required to pay in full).*

Of special interest to doctors is the fact that semi-comprehensive insurance establishes no fee schedules. The companies that sell this insurance agree to pay their share of any normal fee,

omprehensive Health Insurance

year), regardless of how many different illnesses he suffers. And there's usually a "common accident" clause: If two or more members of a family are injured in one accident, only one deductible has to be paid.

Are all kinds of health services covered?

Most semi-comprehensive policies exclude a few things-e.g., dental care; eyeglasses and hearing aids and examinations therefor: elective surgery or other treatment for cosmetic purposes; periodic health checkups.

Is psychiatric care covered?

There seems to be no common pattern. Some policies cover it in the same manner they do other illnesses-although one insurer reports "unfavorable experience [with] advertising firms and similar high-pressure professions." Other policies cover it but require the patient to pay 50 per cent in co-insurance. rather than 20 or 25 per cent. Still other policies entirely exclude psychiatric care. MORE

^{*}Quite a few semi-comprehensive policies waive the co-insurance principle on the first few hundred dollars of hospital expense. A few waive it on the first few hundred dollars of surgical expense.

provided it isn't notably out of line with other doctors' fees in his area. This means the doctor's right to set his own fee isn't as limited as it is under full-service plans with fee schedules.

Nor is the doctor as limited in the type and amount of treatment he can order without going beyond the bounds of the patient's insurance policy. He doesn't have to hospitalize his patient for the insurance to take effect. Nor does he have to hurry a sick person out of the hospital because the insurance benefits are running out. Not ordinarily, anyway, because semi-comprehensive usually pays benefits up to a total of \$5,000 or \$10,000.

Also of special interest to doctors is semi-comprehensive's swift gain in popularity. In a number of key industrial circles, it's proving much more popular than basic health plans, major

More Key Facts About Sem Comp

Is pregnancy usually covered?

Severe complications usually are, and some firms insure normal pregnancy on the same basis that they insure other medical care. Others don't. But a common practice is to make an exception to semi-comprehensive's general rule of no benefit schedules: Normal pregnancy expenses are included under an agreement that provides for lump-sum payment—e.g., \$200 or \$300.

What happens when a patient uses up a sizable part of his maximum benefits?

Many policies include reinstatement provisions. Thus, if a patient with \$5,000 worth of lifetime benefits uses up \$3,000, he may be reinstated for the full \$5,000 once he gives proof of having returned to good health.

Are retired workers covered?

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medical plans, or even a combination of these two types. A good many large corporations have already dropped their basic and/or major medical coverage in favor of semi-comprehensive.

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Employers like it because it's almost always easier to administer than basic plus major medical—and sometimes less expensive. Also, some of them say, it doesn't require the periodic revisions that basic plans require

to meet increases in the cost of medical care.

Employes apparently like it too—once they accept the idea of deductibles and co-insurance. When General Electric offered its workers a choice between semi-comprehensive and basic plus major medical, nearly 96 per cent chose the former.

In total sales, semi-comprehensive still trails major medical, which is also growing rapidly. At

Sem Comprehensive Health Insurance

That depends on the wishes of the company that buys a plan. It's not uncommon for companies to continue coverage on a limited basis—e.g., increase the deductible and impose a maximum of, say, \$2,500 in non-renewable, post-retirement benefits.

Is semi-comprehensive being sold to individuals?

Almost none is being sold, says the Health Insurance Council. It's currently designed primarily for employed groups.

Is semi-comprehensive being sold only by commercial companies?

Yes. Several Blue plans are, however, offering basic health insurance plus some form of major medical coverage.

Are big-name companies buying semi-comprehensive?

Yes. Purchasers to date include General Electric, Studebaker-Packard, Time, Rand McNally, and Warner-Lambert.

Why They Like It

- ▶ The [typical semi-comprehensive] plan...incorporates co-insurance so that the employe is interested in every dollar of claim. It covers all types of . . . charges, regardless of whether hospitalization occurs. It provides a maximum of \$10,000 toward catastrophic claims.—Donald D. Cody, Second Vice President, New York Life Insurance Company.
- ▶ It reduces abuse and misuse encountered under basic plans [e.g., Blue Cross and Blue Shield] . . . does not require frequent revision, [as] basic plans do...eliminates the costly minor claim, but does recognize the accumulation of small, continuing claims. Most important, it accomplishes in one step what basic and major medical accomplish in two.—Dresser Industries, Dallas, Tex.
- ▶ Coverage extends not only to the costs of hospitalization and surgery, but also to the costs of home and office medical care, registered nurses, drugs, X-rays, and even prosthetic appliances . . . After fifteen months of experience we are not aware of any serious drawbacks and, in fact, do not know of any significant change we would make in [our] comprehensive plan if we were now designing it.—G. P. Lehmann, Specialist, Employe Benefits, General Electric Company.
- ▶ It is easier to explain and administer [than basic plus major medical] and less expensive.—J. M. Burrall, Manager, Employe Relations, Scotill Manufacturing Company, Waterbury, Conn.

the end of 1956, reports the Health Insurance Council, some 7,463,000 people had major medical coverage; some 1,413,-

000, semi-comprehensive coverage. But semi-comprehensive's growth in two years has been phenomenal. At the end of 1954,

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Why They Criticize It

- ► [Semi-comprehensive] programs contribute to the increasing cost of medical care . . . Such contracts may well provide the easiest method by which voluntary medical practice can lose its fight against government control .- W. H. Horton, M.D., Executive Director of Connecticut's Blue Shield plan.
- ► The trend is toward too liberal plans which ignore the deductible and co-insurance safeguards and which encourage over-insurance, abuse by the insured individuals, and to a certain extent [abuse] by doctors and hospitals. I am afraid this will result in losses to insurance companies, increases in rates, and possible restrictive action . . . Government control could be a result.-William A. Henning Jr., Assistant Manager, Group Term and Casualty, State Mutual Life Assurance Company.
- ► These plans may induce physicians to prescribe unnecessarily costly and elaborate procedures . . . in order to take maximum advantage of the fee opportunities available to them. While discouraging the type of preventive care and early treatment favored by labor . . . these plans may actually lead to further over-utilization and abuse of hospitals and other expensive medical facilities. -Nelson H. Cruikshank, Director, Department of Social Security, A.F.L.-C.I.O.

only about 100 such policies (covering some 50,000 people) had been written.

So far we've been talking as if all semi-comprehensive policies were the same. Actually, there are many variations. Why?

First, since semi-comprehensive is very young, insurance firms are still experimenting with certain of its features. It will undoubtedly undergo further important revisions.

Second, almost all semi-com-

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What They Urge

- ▶ The profession has a responsibility to encourage development of [semi-comprehensive] policies since they pay the doctor's regular fees less a 20 or 25 per cent co-insurance . . . It is in our own interest . . . Charges to patients protected by health insurance should be on the same basis as if they did not have health insurance.—Robert M. Shelton, M.D., Chairman, Committee on Medical Economics, California Medical Association.
- ▶ The privileges granted to the profession by this type of coverage carry with them certain responsibilities if this form of protection is going to . . . bring needed benefits to the insurance-buying public . . . Any temptation to increase normal fees for professional services should be resisted.—Committee on Prepayment Medical and Hospital Service, A.M.A.
- ▶ We ask of doctors only that they prescribe the same kind and amount of services and make the same charges for insured patients as they would for patients with no insurance protection.

 —Amos Dublin, Supervisor, Group Research and Market Analysis, Metropolitan Life Insurance Company.
- ▶ The coverage is vulnerable to abnormally high charges . . . The active interest of all doctors at the grass-roots level is necessary to prevent the ineffectual dissipation of health insurance resources.—Arthur G. Weaver, Second Vice President, John Hancock Mutual Life Insurance Company.

prehensive insurance is being sold to employed groups. And most policies are tailored to the needs of particular companies. At the moment, most semicomprehensive policies fall into one of three basic patterns. You ought to know the following facts about will be your b

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about them, since these policies will be paying more and more of your bills:

1. The first type applies the same deductible to all kinds of medical expenses and applies coinsurance as soon as the deductible has been paid. Thus, under one policy, the deductible may vary from \$50 to \$100, depending on the employe's salary. The policy then reimburses him for 80 per cent of all his remaining expenses. The limit on benefits is \$5,000 in a lifetime.*

A Different Deductible

- 2. The second type requires a different deductible-or no deductible-on certain medical expenses. Under a policy written by Aetna Life, for example, there's no deductible on in-patient hospital expenses. There is a deductible ranging from \$50 to \$100 on other expenses. And the patient is required to pay 20 per cent of all expenses above the deductible.
- 3. In the third type of semicomprehensive insurance, the deductible may or may not be

applied to all expenses—but coinsurance isn't required on some of them. One policy written by Prudential, for instance, requires a deductible of \$50 or more on all except hospital expenses. Beyond the deductible, the patient pays 20 per cent except on the first \$250 in hospital charges.

Two Major Criticisms

So much for the plus side. Now, what about the minuses? What criticisms are being heard about semi-comprehensive health insurance?

There are two fairly prevalent criticisms of it: (1) Some people don't like its deductible and coinsurance features; (2) some people think it may tend to increase the cost of medical care.

The first criticism comes mainly from people who now have full-service coverage of their basic medical bills. Employers report that they sometimes have trouble persuading them to agree to the idea of paying part of all major bills. Says an officer of a midwestern industrial firm (which offers semi-comprehensive only to its management personnel): "I doubt that workers will ever give up [basic health insurance that [MORE ON 270]

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[&]quot;The limit on this case-in-point policy is low; a more typical limit is \$10,000. In addition to lifetime limits, some policies impose a maximum (e.g., \$5,000) on a particular disability or during a particular expense period (e.g., two years).



Is Your Sixty-Houvee

Aim for more free time, not a lot more money, this man urges: It'll make you more secure against pressures from patients, hospitals, government

An Interview with Verne Burnett

EDITOR'S NOTE: Verne Burnett has been called the dean of U.S. public relations counsel. You might expect an interview with him to be a high-level discourse on public relations. But in response to the questioning of Lois R. Chevalier, MEDICAL ECONOMICS' research director, Mr. Burnett talks with down-to-earth insight about the medical profession's mood today—its causes and its possible cure. Some of his ideas are startling; many hit close to home.

Q. Mr. Burnett, I know that the medical profession has never been one of your clients. Yet you must have thought some about the profession's public relations. It's almost a universal topic for discussion—even among people who are neither doctors nor public relations men.

A. Well, of course I have. As a matter of fact, I'm a member of a hospital board of trustees. I also work with industries interested in medical care. Though I'm an outsider as far as medicine is concerned, I'm actually a pretty close neighbor.

Q. What are some of your observations? What one

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thing stands out most in your mind about the medical profession today?

A. It's the doctors' widespread feeling that they're under heavy pressure from forces beyond their control. It permeates their thinking as individuals and their policies as organized groups.

Q. Do you think there's a real basis for this fear of encroachment?

A. A few years ago, under the Truman Administration, I think the fear was justified. Socialized medicine was a real threat then. The A.M.A.'s program to defeat it was a success—at least on the surface. Certainly the threat isn't in plain sight today. But it may be strong under the surface still.

Q. Does this account for the mood of the medical profession today?

A. It contributes to the mood. But it isn't the only factor. The doctor feels his independence threatened by several other forces. Even his patients represent a kind of threat.

Q. What do you mean?

A. Patients are reading more and more about medicine. They get excited by articles about new drugs and treatments. They sometimes come into the doctor's office, not soliciting his help and advice, but demanding that he

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provide them with what they want. The new drugs come out so fast that the busy doctor has trouble keeping up with them. He feels frustrated when the patient finds out about some new medical advance before he does.

Hospital Pressures

For another thing, he sometimes feels he's under pressure from the governing board of his hospital. Time was when doctors just about ran the hospitals. They were on the boards. In some communities they owned the hospitals, as they now own their offices. But today the hospital's ultimate control is in the hands of bankers, lawyers, businessmen, and other people outside the medical profession. The doctor often feels that these people don't have any real understanding of doctors' problems.

He's also aware of the bigness and power of the industrial and financial world—including the unions and health-insuring organizations. Here is a large instrument for making changes in the economics of medical care over which he has no direct control. More and more employers and unions are getting into the health problems of employes.

All in all, the doctor feels that the Government is a sleeping giant; that some patients may be out to show him up; that he's obliged to lean more than he'd like on the nonmedical organizations that are at work in the health field. He functions largely as a lone individual surrounded by great aggregates.

Q. What's the effect of this on him?

A. He feels constantly harassed.

Is There a Remedy?

Q. What do you think he should do about it? Does he just have to live with this thing?

A. Well, I wouldn't say that. There's usually something that can be done about any situation that's hard to tolerate.

Q. In this case, what?

A. What would the doctor do with a perplexing medical case? He'd define the problem first. He'd pinpoint what was wrong. To do this, he'd have to have some insight combined with some thorough research.

I know there's been a lot of public opinion research and doctor opinion research. But it seems to me that perhaps a lot of it has not been deep enough to proble

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Q. That's the criticism to which all so-called social science research is subject, isn't it?

A. To some extent it is. And we all have to recognize that some elements in the doctors' life just can't be changed—unless we get more doctors, so each man won't be overworked. The public's chief criticism of doctors now, as shown by the research that has been done, is that they are too impersonal, they do not give enough time and enough attention to the patient as a human being.

Unfamiliar Faces

I know examples of this; everybody does. We've all heard of the specialist who doesn't even recognize his patients' faces when he meets them on the streetthough he does recall them when they consult him again and he sees his previous handiwork.

What's the reason for this? Basically, it's that the man is overworked. He's in the operating room at 7 in the morning, and he works steadily until 6 at night. He works on Saturdays and Sundays too. His work is hard and complicated. He has to run all the time to keep up with the advances in his specialty. He's bowed down by the scientific reading he has to do and by the unsatisfied desires of his patients for a little more psychological support.

How He Reacts

His reaction is to cut out the nonessentials—just eliminate them. He puts his effort into being a superior technician and lets the rest go. He becomes an increasingly efficient mechanic, as it were, and the patient who wants comforting has to look for it elsewhere.

Q. But this doesn't really solve his problem, does it?

A. Of course not. In some ways it aggravates it. He doesn't feel any more secure about his public relations and the big forces that surround him just because he can't take time to think about them. They're still likely to cause him some anxiety, because he can never really shut them out completely.

Q. Are you implying that the first approach to the doctor's problem is to cut down his working day?

A. Perhaps.

Q. But if you ask him to do

that, you're asking him to cut his income. A man who sees forty patients a day isn't voluntarily going to begin seeing twenty patients a day, is he? The patients would have to pay double the previous fees, or the doctor's income would drop.

A. He's not going to go that far voluntarily, I know. And no one could expect him to. Yet there may be ways the doctor can

shorten his hours without arbitrarily reducing his income. He can scrupulously avoid doing any kind of work in his office that can be done just as well by a secretary, a nurse, a clerk, or an independent accountant. He ought to analyze his activities for a week or a month; he might be surprised to see how many of them are things he doesn't really need to be doing.



"She says that pill she was to take four times a day came up twice all right; but she lost it on the third go."

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Then he might consider the economies (for himself and for patients) in some kind of group or association of doctors. He might cut his overhead—time as well as cost—by sharing it with other doctors; he might save time and money for patients by the department-store principle of offering a wide variety of things, all conveniently located under one roof.

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Beyond that, he can do some serious thinking about the economic trends of our times. Look at incomes since the turn of the century. By and large, the rest of the American public has taken most of its increase in productivity in the form of increased leisure time. Some labor unions are now beginning to talk seriously of the thirty-hour week. The average doctor works just about twice that long each week!

More Money, Less Time

In fact, since the turn of the century, the doctor has taken his greater productivity in the form of money. He's taking less, rather than more, leisure time. How long will he want to work longer hours than almost anybody else in the country? I know some doctors already who're asking: "Is

the sixty-hour week really worth it?"

Sometimes, I know, they're working long hours out of pure altruism. Maybe there just isn't anybody else available to take care of their patients. I don't know how they stand it. It's certainly not like working in a factory sixty hours a week. It's a grueling job.

The Tired Men

When I see my friends who are physicians at a social occasion, they're often tired men—the most tired of anybody there. And I hear some of them say that they're warning young men not to go into medicine—because of the long hours, the lack of personal life, the pressures—this feeling of anxiety and defensiveness that we discussed at first.

Q. Then your prescription for the doctor is more leisure, even at some sacrifice of income?

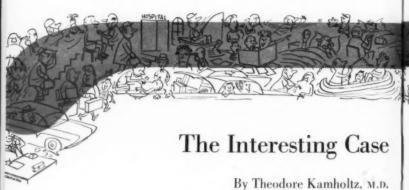
A. Yes, and I think the sacrifice of income would be small, if the doctor looked for ways to benefit from better organization. If I were a doctor, the first thing I'd look for would be some way to get the clerical work, the billing procedures, the lab work, the various ancillary services all or-

ganized for maximum efficiency at lowest cost-with a minimum of the doctor's attention.

After all, what this man needs most of all is one more free hour

a day. He needs a chance to sit down and contemplate. If he'd begin with that, he'd get more perspective on his problems; he'd be able to measure this vague

threat comerelaxe the re ones.



The doctor's darling is not a patient or a disease but an impersonal entity called the Interesting Case. Every day it is newly introduced and recited in the jargon of the auctioneer's spiel. Then it departs amid appropriate smiles, guffaws, sighs, or long low whistles.

To define this phenomenon is difficult. One man's champagne is another man's dishwater. What will move one doctor to spend weeks in the library trying to find cases to parallel his own unique one will move another to monumental yawns. Here, then, is a strange bouquet of the unusual, the challenging, the warmly human. It is also a vanity, often peculiar to the individual doctor.

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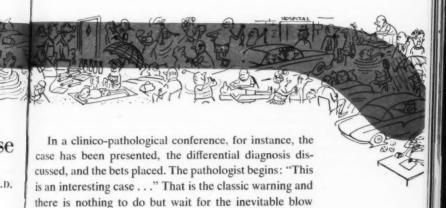
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And he might find that by being a more relaxed person he'd win still more of the patient loyalty that is his ultimate security against all threats.



to fall.

To the pathologist the case is interesting in direct proportion to how far wrong the diagnosis was. Added flavor is obtained upon demonstrating (with the carcass cold and the returns all in) how easily the correct diagnosis could have been made, a less disastrous therapy em-

The radiologist also has Interesting Cases. They are inclined to be showy and dramatic, and understandably so. When you present a pictorial subject, you want something that has impact and is apparent to the last row of the auditorium. Something like a couple of snowballs

ployed, and the unfortunate result avoided.

in the chest from a renal carcinoma is a cinch to be an Interesting Case.

The surgeon establishes his criteria for an Interesting Case on this tripod: (1) The case is operable; (2) a radical new plumbing system can be installed; (3) the patient will live to tell others about it. If the patient occupies the bed too long, has residual complaints, or fails to recover, his status as an Interesting Case diminishes.

What Interests the Internist

For the internist, it is rather the Case of the Interesting Case. It is the unsolved mystery, replete with clues and red herrings. The action twines in and out of the laboratory, the armchair, and the bedside, until by sheer deduction the suspense is broken and the culprit identified. The patient has an ovarian carcinoma with metastases to the adrenals, and the production of an Addisonian syndrome. The outlook is fatal; there is no therapy for this patient-but it was an Interesting Case.

The gynecologist is more direct. The more nearly the female perineum approaches the cloaca, the more interesting the case.

The gyn. man's alter ego, the obstetrician, is more quantitative. The zenith of his interest is the Dionne quintuplets or better; it subsides through quadruplets and triplets to a mere flicker at twins.

An Obvious Clue

The allergist discovers that the Interesting Case is one that has been long missed, with the solution right under the nose all the time. Mr. X, for example, is allergic to short-haired fur such as is found at the hem of his wife's best nightgown. An Interesting Case.

Such is the elasticity of the Interesting Case that the psychiatrist finds any case of his interesting, while the general practitioner includes only those for which he is paid. The neurosurgeon locates the lesions in his particularly Interesting Case in a cozy, inaccessible corner of the hypothalamus.

When I get ill, I want the dull-

est, most ordinary, routine disease with an easy cure and a quiet convalescence. The Interesting Case is the spice, the zest of medicine. I hope I shall never be one.

Before and After You Sign That Lease

Three legal authorities tell what clauses to ask for beforehand—and what rights you have afterwards

1. Before You Sign

By Edward T. Welch, LL.B.

After a long search for more adequate quarters than his cramped two-room office, a midwestern G.P. found a vacant four-room suite on the ground floor of a large apartment building. It seemed like an ideal set-up, except that it needed some major repairs. But the owner described at great length the improvements he would make "now that I've got a tenant who'll appreciate them." Catching the landlord's enthusiasm, the G.P. signed a long-term lease.

When a couple of weeks went by without any repairs having been made, he started to worry. A phone call to the landlord confirmed his suspicions. "I understood that you were to pay for those repairs," said the landlord. Stuck with his hastily signed lease, the doctor had no

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choice but to foot the billswhich came to almost \$1,000 before the office was fit to practice in.

"Look before you lease" has been shouted at generations of tenants. Yet the average tenant still signs up with only the foggiest notion of what's in the fine print-and without making any attempt to modify objectionable features.

Physician-tenants are in a far better position to wangle concessions than is sometimes imagined. They usually pay higher rents for their offices than comparable residential quarters command. Moreover, in some areas where postwar apartment construction has been heavy, there's actually a tenant's market in professional suites.

In any event, it will pay you to go over your lease line by line (preferably with a lawyer). Here are the main points to watch:

How to Read It

Description of premises. Make sure that the lease describes completely what you're getting for your rent money. Besides listing the rooms included, it should mention any space you've been promised in basement, attic, ga-

rage, or grounds. If you're renting furnished quarters, it should describe the furnishings accurately. Some landlords aren't above using expensive draperies and furnishings as bait to catch an unwary tenant; then, as soon as they have the tenant hooked, they replace the good furniture with secondhand relics.

Utilities. Your lease should also stipulate what services the landlord is to provide. If he's to pay for heat, gas, and electricity, let him put it in writing. And, unless you care to risk paying for repairs to worn-out plumbing, have it stated that he's to keep the premises habitable.

Alterations. No matter how adequate your office seems when you move in, you'll probably want to make changes as time goes by. So it's a good idea to write into your lease (1) the extent to which you may alter the premises; and (2) who's to pay for any special plumbing, gas, and electrical work that you require.

If you expect to install any equipment, stipulate that you can take it with you when you leave. Otherwise you may find yourself in the same boat with a doctor who had a pedal-controlled sink and stall then B

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and some expensive cabinets installed, and then had to leave them behind when he moved.

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Before you sign a lease—and certainly before you start knocking down walls—make certain that you won't have to restore the premises to their original condition when you move out. One medical man built a laboratory, a darkroom, and other special features into space he rented in a private home. When his lease expired, he was presented with a bill for \$1,500. It would cost that much, said the landlord, to fix up the rooms the way they'd been before.

Escape clauses. Try to get an unrestricted privilege to assign or sublet—or, at least, suggest a clause like this: "The tenant shall not assign . . . without the landlord's consent, but such consent shall not be unreasonably withheld."

A Southern physician, forced by ill health to put his practice on the market, learned the hard way that he couldn't sublet without his landlord's consent. He got the consent, all right—after he'd given the landlord \$2,000.

Another doctor decided to offset part of the cost of his highrent office by subletting it to a



"How'd you like to spend the rest of your life free of medical bills?"

colleague during the mornings. His landlord, on hearing of the plan, pointed to a clause in the lease which forbade his subletting "any portion" of the premises without written consent. Seeing that the consent wasn't to be had cheaply, the M.D. gave up his idea.

There would have been no problem if his lease had simply stated that "the tenant shall not sublet the demised premises without the written consent of the landlord." Where the wording runs like this, the courts have ruled that subletting on a parttime basis (or subletting part of an office) is permissible.

If you can't get an unrestricted privilege to assign, try to win the right to terminate the lease if you must move for professional or health reasons—or if you're called into service. A young New Jersey physician, tapped by Uncle Sam last year, had to pay four months' rent—over \$500—to get out of his lease. At that, he considered himself lucky; a really



"Oh, oh! We forgot something yesterday, Miss Schnur."

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While you're at it, specify that you're to be relieved of further liability as soon as you've assigned your lease. Otherwise you may wind up guaranteeing your assignee's obligations.

Renewals. Obviously, it's worth your while to get an option to renew your lease. But the important thing about renewal clauses is not only what they say but whether you know what they say.

Sometimes, for example, a lease is renewed by written notice on or before a certain date; sometimes it's renewed automatically by failure to give notice. If, in the latter case, you neglect to give notice before a specified date, you risk being held liable for an additional term's rent.

Here are some other points to remember about leases:

¶ Chances are, your lease will contain a "viewing clause." This gives your landlord the privilege of showing the place to prospects for a specified period before your term runs out. To minimize this nuisance, try to hold the viewing period to a reasonable length of time—say, thirty days.

¶ If you're renting space that was previously residential, check to make sure that the practice of medicine isn't prohibited there by zoning laws or restrictions in the deed. If possible, have the landlord warrant that the practice of medicine is legal in that space.

¶ In some states, unjust though it seems, you may have to keep on paying rent if your office is destroyed by fire. To guard against this possibility, better tack on a protective clause.

2. After You Sign

By Edward Goldman, LL.B., and Carl Shapiro, LL.B.

An apartment-dwelling doctor in an eastern city recently bought a television set. But he neglected to get his landlord's permission to put up an outdoor antenna. When the landlord saw the antenna on his roof, he gave the physician a choice: either take down the aerial or pay a stiff rent for the roof space.

The doctor refused to do either. Whereupon the landlord won a court order directing him to remove the antenna and pay court costs besides.

Room for Argument

If you rent an office or apartment, you're probably on better terms with your landlord than the doctor cited. Even so, there's plenty of room for dispute in almost any tenant-landlord relationship. Witness the following cases:

A young physician just starting private practice signed a three-year lease for his office. It called for him to pay \$100 a month the first year, \$125 a month the second and third years.

A 'Reasonable' Landlord

His practice was slower to develop than he'd expected. So when the first year ran out, he told his landlord he couldn't afford the increase. The landlord, apparently anxious to help out, agreed verbally to go along at the \$100 figure. Each month thereafter, then, the doctor wrote a check for \$100 with the nota-

tion "in payment of the current month's rent." The landlord accepted the checks and banked them.

Eighteen months later, however, he suddenly demanded all the extra rent called for in the lease (by then, \$450). The doctor refused to pay. The landlord thereupon got a money judgment and eviction notice against him. The tenant's mistake: failing to have the rent adjustment entered in the lease itself.

If You Stay Too Long

A lease can cause you trouble even after it has expired. Reason: In many states, a landlord can hold you for an entire year's rent if you overstay your lease even a few days. That's what happened to a midwestern radiologist. He was giving up his third-floor, walk-up office for a street-level office in a nearby building. He wrote his landlord that he was closing his lease and planned to move Feb. 15—a month after the lease was to expire.

The landlord didn't say a word until the radiologist started moving his equipment the second week in February. Then he sent the doctor a note. "Your written "Sir of the tend for held mittered

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lease ran out January 14," it said.
"Since you're still in possession
of the office after that date, I intend to hold you liable as tenant
for another year." And the claim
held up in court. Already committed to his new office, the
radiologist wound up paying two
rents for eleven months.

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Sometimes you can walk into a carefully baited trap simply by taking what your lease says to be law. Landlords often insert clauses that they know can't be enforced in court. These clauses keep many a naive tenant from following up a legitimate complaint. To illustrate:

'Exemption' Clause

A doctor renting the first floor of a two-family house was hit by a screen falling from a second-story window. The landlord had known for a month that the screen was loose but had made no effort to fix it. He was clearly at fault. But the doctor had noticed a clause in his lease which stated that the landlord was "exempt" from any liability for negligence.

Any court would have denied the validity of that clause as against public policy. But the M.D. took the clause at its face value—and missed a chance to win a verdict for the spinal injuries he'd suffered.

Does that make a landlord always liable for injuries caused by a defect in his property? Not by a long shot. He's generally in the clear if something goes wrong that he couldn't be expected to know about. In effect, that puts it up to the doctor himself to see that the office he rents is in safe condition.

An Unexpected Blow

A pediatrician, for example, noticed a damp spot on the ceiling of his waiting room, caused apparently by a leaking radiator on the floor above. Somehow he never got around to telling his landlord about it. The water continued to soak the plaster. Finally a big chunk tore loose, striking a youngster seated below. The doctor—not the landlord—had to pay the boy's medical expenses.

He Was Lucky

"And you got off easy," his lawyer told him later. "If the boy's parents had wanted to be tough about it, they could have taken you into court for negligence."



Planning Your Family's Financia

Make the Most of the I

A simplified explanation of the most important money-saver in the Federal estate tax law

By René A. Wormser, LL.B.

In the eyes of the Internal Revenue Service, matrimony didn't really come into its own until nine years ago. It was in 1948 that Federal tax laws were amended to allow you:

 To cut your income tax by filing a joint return with your wife; and

2. To cut your estate tax by using the marital deduction.

Expressed in simplest terms, the marital deduction amounts to this: You can exclude up to one-half your estate from Federal estate taxes by passing property on to your surviving spouse in specified ways. I'll explain in a moment what those ways are.

Using the marital deduction, you may even find it possible to *eliminate* Federal estate taxes. For example, you

THE AUTHOR combines a busy law practice with teaching, writing, and lecturing. He's chairman of the advanced estate-planning panels at the New York Practising Law Institute. He's also the author of a number of books on estate planning. One of them, "Personal Estate Planning in a Changing World," is considered the standard layman's guide to the subject.

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can leave your wife an estate of up to \$120,000 completely free of such taxes. The first \$60,000 of this amount is exempt in any case; and the second \$60,000 can be passed to her tax-free if you make proper use of the marital deduction.

State tax laws vary so much that they can't be discussed in general terms. But state levies are small in comparison with Uncle Sam's. For the most part, they can also be taken as a credit against the Federal tax.

The table on page 150 shows the tax savings made possible by proper use of the marital deduction. In this table, the New York State tax has been combined with the Federal tax to give a typical result. It wouldn't be much different in any other state.

The table uses the estate tax rates in effect today. It's not too likely that these will be increased soon, since the estate tax is one of the smaller sources of Federal revenue. It seems equally unlikely that the marital deduction will soon be abolished or reduced.

The marital deduction covers not only property left by will but also anything else that's taxable at your death: taxable life insurance principal, taxable trusts and jointly held property, and so on. To figure your maximum marital deduction, you estimate the value of your entire taxable estate, subtract such things as administration expenses, and halve the result.

But note carefully that the property must qualify under certain rules if it's to be subject to the marital deduction. Here's the basic principle:

Your wife must either (1) get the property outright, or (2) get all the income from it for life and have unrestricted right to dispose of the principal at or before her death. Unless these two conditions are met, the marital deduction doesn't apply.

Suppose you leave your life insurance proceeds with your insurance company. And suppose the arrangement gives all the income or annuity installments to your wife, allowing her either to

How the Marital Deduction Cuts Taxes

Amount of Estate	Taxes Without Marital Deduction*		Taxes With Marital Deduction*		
\$ 65,000	\$	800	\$	325	
70,000		1,200		350	
80,000		2,400		400	
100,000		5,800		500	
120,000	1	10,540		600	
150,000	1	19,000		1,800	
160,000	2	21,840	;	2,400	
200,000	3	34,000		5,800	
500,000	13	30,000	4	9,300	

Taxes shown are the sum of the Federal estate tax and the New York estate tax. Figures for other states would change the totals only slightly. life or

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Your insurance proceeds will then qualify for the marital deduction.

But now suppose you leave your estate in trust. Suppose you specify that your wife is to receive the income for life and that the principal is then to go to your children.

The marital deduction does not apply. Reason: Your wife lacks the right to dispose of the principal as she sees fit.

She Must Decide

And it won't help matters merely to empower her to decide which of your children should get how much. Your wife must be absolutely free to leave the principal to anyone at all—from the children of her second husband to a dog-and-cat hospital.

To what extent should you plan your estate to take advantage of the marital deduction? Well, you've got to remember that property passing tax-free to your wife under the marital deduction will be taxed as part of her estate on some future day. You may have to calculate at what point immediate tax savings

(to the benefit of your wife) are offset by subsequent tax sacrifices (by the eventual heirs).

If she has no money of her own, there's usually no choice: You'll undoubtedly want to plan your estate to take all possible advantage of the marital deduction. But if she has independent means, some further figuring may be in order. For example:

Your wife will get a life income on the money saved through use of the marital deduction. Some guesstimate of that income should be made in weighing your death taxes against hers.

Also, she may reduce her estate taxes by gifts during her lifetime to your children. Over the years, she may even be able to give away the entire amount of the marital deduction in sums small enough to be free of gift taxes. If so, the marital deduction will represent a tax saving passed down to your children.

Is It for You?

Aside from the tax factors, you'll want to consider whether use of the marital deduction suits your particular family. Each man must decide for himself whether it's safe to give his wife her full share of his estate outright. Will

she administer it carefully? Is it prudent to give her the unrestricted right to distribute the principal of a trust at her death? Would she possibly favor one child over another, or give some of your savings to outsiders?

Questions like these show why some men prefer not to use the marital deduction. They'd rather lose more in death levies for the sake of being sure that their own plans will be fulfilled, that their family's security will be safeguarded, and that their selection of ultimate heirs will be assured.

Frequently the best answer is a hedge. A typical doctor's estate plan might divide the wife's share of the estate into two trusts. In one (tax-free), she could dispose of the principal at her death to anyone she chose; in the other (taxable), the principal goes automatically to the children.

I'll take up such trusts in greater detail in subsequent articles. Meanwhile, remember that the marital deduction can mean big savings-but that tax savings should always be secondary to your main objectives.

Germ of an Idea

While delivering the major address at a medical meeting in Philadelphia, a well-known physician announced that he would answer questions afterwards if they were written out and sent up to him. At the conclusion of his speech, he began answering the questions-most of them highly technical. Then he read this one: "Is it true that mouth gargles really kill germs?"

An embarrassed silence filled the hall. Everyone wondered who would have the nerve to submit such a question. The speaker paused a second and then replied:

"Yes, they do. When the germs see the gargle coming, they all die laughing." --- D. R. MARTIN

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J. rer is state chare s. In pose ch to other

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How You Can Make Your Office Look Larger

Cramped, cluttered rooms can drive patients away —unless you borrow some of the decorators' tricks

By Lois Hoffman

Knocking out walls is an expensive undertaking—and one that most landlords won't permit. What can you do, then, if you're obliged to practice in an office whose rooms are the wrong size or shape?

You can use colors and furnishings that trick the eye into seeing what isn't really there. For instance:

You can increase the apparent floor space by substituting small-scale chairs for overstuffed monsters and by making floor and walls the same color.

You can push the walls outward—optically, not literally—by painting an extra-high ceiling a dark color.

And you can cover badly spaced windows with wall-towall, floor-to-ceiling draperies, which also create the illusion of spaciousness.

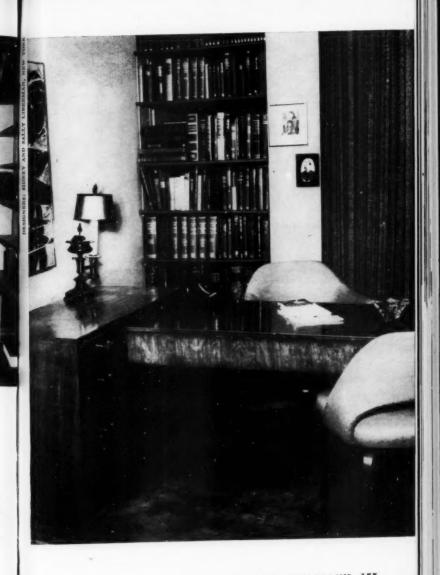
For an object lesson in how these and other decoraing tricks can transform an ugly-duckling office, see the before-and-after pictures of two Manhattan professional suites on the following pages.

MAKING YOUR OFFICE LOOK LARGER



CLUTTERED, NARROW ROOM (8' x 14') used for eye exams had a useless alcove and a projecting column behind the cramped kneehole desk. The doctor's supplies were distributed among his desk, two small tables, and the bottom of the towering bookcase.

ILLUSION OF SPACIOUSNESS was created by simplifying the lines of the room. Built-in bookshelves and floor-to-ceiling draperies make one plane of window wall; thus it looks wider. Storage space in the desk now holds all business and ophthalmological supplies.



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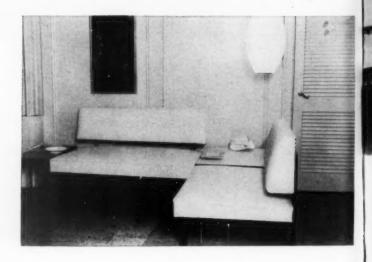
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MAKING YOUR OFFICE LOOK LARGER



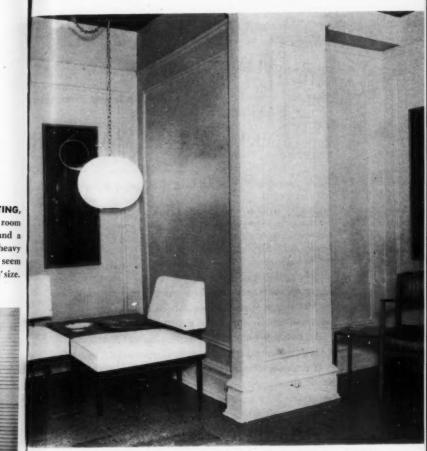
GLOOMY AND UNINVITING.

this basement reception room had an awkward shape and a high ceiling. The dark, heavy furniture made the room seem even smaller than its 12'x 14' size.



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SIMILAR FURNITURE GROUPINGS, repeated on east [€] and west [♣] walls, help make the done-over room seem more spacious. So does the contrast between the pastel walls and the ceiling, which was painted dark blue. Backed by solid panels for privacy, louvered doors such as the one shown at left make visitors feel less shut-in than slab doors would. To minimize maintenance, decorators chose plastics for floor and upholstery. END

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Take a lesson from these malprac

7. THE CASE OF THI

By Xavier F. Warren

EDITOR'S NOTE: Here is the seventh in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although identifying details have been changed, the stories accurately portray recent happenings.

There are sound economic reasons for a doctor's keeping his fees within "usual" limits. There are also sound legal reasons—among them this one:

An oversize bill can boomerang against the doctor if it turns up as plaintiff's evidence in a malpractice suit.

A dramatic illustration of this that I'll always remember is what happened to an excellent surgeon I'll have to call Dr. X.

He was called to attend a man who'd suffered a crushing blow to his right leg when hit by an automobile. The doctor tried to repair the vessels and nerves, but eventually the leg had to come off just below the knee. Dr. X did the amputation himself.

A few days later, the patient's attorney came to the doctor's office. He explained that he was preparing the patient's legal case against the driver of the car that

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OFTHE SCALED-UP FEE

hit him. Then, as Dr. X told me later, the conversation went like this:

LAWYER: How much of a bill do you expect to submit for the amputation?

DOCTOR: Two hundred and fifty dollars—my usual fee.

LAWYER: Tell me, Doctor: Isn't it true that you do a lot of surgery for poor people and that you never get paid for it?

DOCTOR: Sure. Sometimes I don't get paid for work on rich people, either.

LAWYER: Exactly. So if a patient can well afford to pay more, it's ethical for you to charge more than your usual fee?

DOCTOR: I guess that's right, depending on the circumstances.

LAWYER: Well, in this case the liability is clear-cut. Your patient was a pedestrian. The driver of the car that hit him has \$50,000 insurance coverage. And with an amputation, the jury is bound to be sympathetic. Your patient is going to collect at least \$30,000 out of this. Now, isn't a fee of \$250 pretty small for a patient with \$30,000 to \$50,000 in the bank? What would a top

orthopedic surgeon charge the richest man in town for an amputation?

DOCTOR: Maybe \$500. I don't know.

LAWYER: I do know. I have some pretty rich clients. A really big man, say a corporation head, would expect to pay his surgeon \$1,000. It would help the case if you submitted a bill for \$1,000.

DOCTOR: Are you asking this for your client or for yourself?

LAWYER: Look, Doctor, I want to win as much money for my client as possible. That's my duty. I think a large bill will help the case, and I'm doing my duty by recommending it . . .

In the end, Dr. X agreed to scale up his surgical fee to \$1,000. He sent a bill for that amount, telling himself that the lawyer had a point and that he'd undoubtedly be able to argue it effectively in court, just as he had in the doctor's office.

But the case never got to court. It was settled between the lawyers for \$18,000. Dr. X learned later that the amount of the settlement had depended in part on the medical expenses. So the scaled-up surgical bill was a help in getting the settlement.

It was no help to Dr. X, how-

ever. He wasn't too surprised to receive only his original \$250 surgical fee from the obviously tricky lawyer. But Dr. X was surprised when the same lawyer and the same patient filed another suit-against him. They said he'd been negligent in not saving the leg.

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When Dr. X told me this story, I realized the spot he was in. The lawyer still possessed the scaledup bill for \$1,000. He could use it to brand the doctor as an arrant money-grabber.

What's more, the lawyer had copied every blessed line on Dr. X's record of the case. The doctor had seen no reason to deny him full access when they were both "on the same side." So the lawyer could now fine-comb the file for something that looked like negligence. A delay in responding to a call, not testing the man's reflexes at the fourth examination, failure to summon a consultant-almost anything would do, once the jury believed that Dr. X was more interested in money than in medicine.

Our home office wanted to go to trial anyway. They figured that the claim of negligence might collapse. They hated paying tribute to this slick attorney.

But Dr. X was so burdened by guilt and anxiety that he couldn't sleep or eat. He told me he was thinking of withdrawing his daughter from college to save the tuition money against the big

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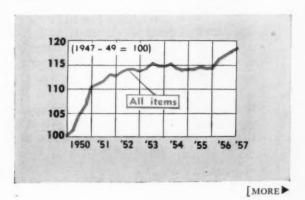
judgment he was sure there'd be.

That's when we decided to settle. And that's when Dr. X told me he'd vowed never again to scale his fees above their usual range.

The Prices You'll Pay

Are living costs bound to go higher and higher? This new study suggests a surprising answer: No!

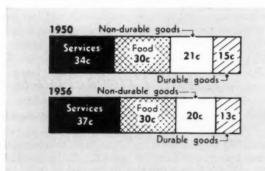
What's been happening to the cost of living in the past six years? The Bureau of Labor Statistics chart printed below shows clearly the general characteristics of the period—a sharp upsurge after the Korean War began, stability from late 1952 to early 1956, and a creeping rise since then:



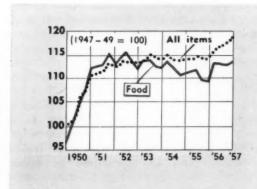
MEDICAL ECONOMICS · JULY 1957 161

THE PRICES YOU'LL PAY

What has generally gone unrecognized is that prices of goods, on the whole, were inching downward, to be balanced by rises in the price of services. Take the Commerce Department's figures on how the consumer dollar was spent in 1950 and 1956:



A new series of B.L.S. charts shows even better that prices in the various sectors during much of this period were moving quite differently. Start with food:



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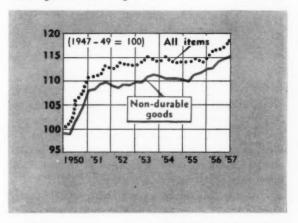
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One obvious characteristic of the preceding line is that food prices have a seasonal component—up in the summer, lower the rest of the year. But with this factor allowed for, it is clear that food prices sank gently but steadily from mid-1952 until February of last year. Then they started up again.

Next there is the line for consumer non-durable or "soft" goods, excluding food:



This line covers clothing and shoes, oil and gasoline, coal and fuel oil for heating the home, cigarettes, beer and alcohol, and household textiles—all things that get used up relatively quickly. This line was stable from early 1951 until mid-1955, when it started to rise once more.

A check on individual items reveals that clothing and household textile prices since early 1951 have scarcely risen at all. But there has been an inching upward of cigarettes, oil and gasoline, beer and alcohol, and home heating fuel.

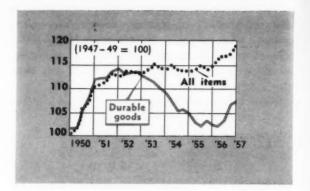
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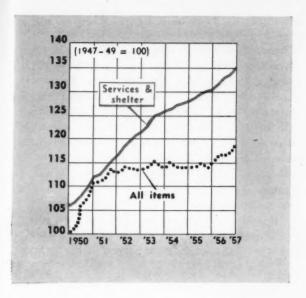
The next line [above] shows much sharper gyrations. [It represents] consumer durable or "hard" goods.

These, of course, are automobiles, washing machines and other appliances, and furniture. Although most of them use a lot of steel, which has steadily risen in price, retail competition drove the prices of these durables down sharply starting in early 1953.

Last year they turned around and rose more sharply than any other group of items. But the sharpness of this increase after the middle of the year reflects almost entirely the increase in actual buyers' prices of the new cars.

With the advent of the new model-year, dealer prices rose and dealer discounts to customers became much less. Discounts have long since started to reappear, and already the durables line has shown unmistakable signs of drifting downward again.

This article is condensed from a report prepared by Edwin L. Dale Jr. for The New York Times, It appears here by special arrangement with that newspaper.



Finally [above], there is the line that [represents] services and shelter.

This covers a tremendous variety of items: haircuts and TV repair, subway fares and telephone service, rents and the price of houses, auto insurance and mortgage interest, local property taxes and auto repair, medical care and home maintenance, train fares and gas and electricity.

Practically the entire list has risen steadily over the six years. The line jumped far less steeply than the others when there was general inflation at the time of the Korean War, but it scarcely leveled off at all during the subsequent price stability.

For many of these prices the heart of the problem

appears to be the productivity of labor. Wages in these sectors keep rising gently with general wage levels, but it is frequently difficult to offset wage increases in the service fields with new machinery which increases output per worker. This may be an insoluble problem. Prices of haircuts and auto repairs are quite likely to keep rising.

But the experience of the two periods of stability since World War II indicates that this sort of price increase need not mean an inevitable inching upward of the cost of living. The reason, obviously, is that it may be balanced by price declines where labor productivity is high and rising.

How to bring about these price declines is another story. It involves Government monetary and fiscal policies and other things as well. But our experience since World War II indicates that it can happen.

Juicy Story

The patient had cirrhosis of the liver and rapidly accumulated ascitic fluid, despite frequent abdominal taps. The chief of service suggested that the ascitic fluid be collected under sterile conditions in flasks, then returned to the patient via intravenous infusion. The job fell to me.

I collected several thousand cc. of the yellow fluid in liter flasks and stored it in the icebox in the examining room of the ward. I was amazed the next day, when I returned to give the first infusion, to find that all the flasks had disappeared. Discreet inquiry revealed the fate of the missing ascitic fluid: It had been served to the patients as fruit juice!

It is a sad commentary on the food at this particular institution that no complaints were recorded.

-IRWIN HOFFMAN, M.D.



What Your Delegates Decided

From pep pills to labor unions, from fee fixing to Social Security referenda, from tax deductions to hospital staff assessments—that's how it went during the A.M.A. delegates' week at the Waldorf

By Hugh C. Sherwood

If you saw the newspaper headlines, you may have concluded that the hottest issue at the A.M.A.'s annual session last month in New York was the alleged use of "pep pills" by track stars and other athletes. And the truth is, the headlined charges did create a stir among the doctor-delegates. One of their reference committees said it had been given "a shocking picture of widespread and indiscriminate use" of amphetamine and other stimulants. As a result, the delegates called on the A.M.A. Board of Trustees to begin a long-term investigation of

A.M.A. Quotes

From Dr. Dwight H. Murray, outgoing A.M.A. President: "During my stewardship... I made on-the-spot checks of the so-called 'doctor shortage'... My report to you is that there is no over-all doctor shortage ... [But] there is a shortage of physicians in general practice—in urban centers as well as in rural sections. And I might add that in a few areas there is an oversupply of those limiting their practice to a specialty..."

From Dr. David B. Allman, the new A.M.A. President: "When the physician ventures into the realm of public affairs, he frequently is accused of being too conservative. Of course he is conservative—in the best sense of the word . . . In medicine, the physician knows the cruel delusion of quack remedies, crackpot panaceas, and premature acceptance of unproven drugs. In public affairs, likewise, he sees through the delusion of pie-in-the-sky promises which . . . are based . . . on vote-gathering potentialities."

what they called a "vicious practice."

Headlines notwithstanding, the delegates' hottest discussions ranged far beyond clinical problems. Labor, hospitals, Government—the A.M.A. policymakers tackled them all.

What follows is a digest of their decisions. It capsules the twenty-odd A.M.A. actions of greatest interest to the doctors back home.

One action looms above the others in apparent impact: the approval of a new, short, streamlined code of medical ethics (see page 244 for full details). But a related action may prove the real sleeper of the session: Delegates voted to recognize state medical society codes of medical ethics as binding, "provided they are not inconsistent or in conflict with" the A.M.A. constitution and by-laws.

State societies were also granted the right to enforce their own codes. This move was sponsored by New York delegates, who said such codes were needed because the A.M.A. code is too general to cover all local conditions.

In other major actions, the A.M.A. House of Delegates:

1957 Medical Economics Awards

\$500 for the best original article written by a physician and found acceptable for publication

\$300-\$100 for all other original articles written by physicians and found acceptable for publication

\$50-\$10 for article ideas submitted by physicians and found suitable for development by MEDICAL ECONOMICS' staff

Fees for service, you might call these awards. Fees for what service? For distilling something valuable out of your practice-connected experiences and putting it in writing for the benefit of doctors everywhere. Your contribution can be either an article or an article idea.

Your article will have the best chance of winning if it's (a) between 1,000 and 3,000 words long; (b) filled with examples, anecdotes, and cases in point drawn from actual experience; and (c) limited to just one aspect of any broad subject in our field—fees, for example, or practice management, or even medical humor.

Your article idea will have the best chance of winning if it's (a) between 100 and 300 words long; (b) specific rather than general; and (c) detailed enough so that our editors will understand exactly the economic professional, or personal problem you have in mind.

Entries must be postmarked no later than Dec. 31, 1957, and addressed to Awards Editor, MEDICAL ECONOMICS. Oradell, N. J. Manuscripts should be typed, double-spaced, on one side of the paper only, and accompanied by a self-addressed envelope and return postage.

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A.M.A. Plaudits

To Dr. Gunnar Gundersen, La-Crosse (Wis.) surgeon, who was named president-elect of the A.M.A. One of six nationally known brothers, he currently practices in a group with three of them.

To Dr. Tom Spies, head of the department of nutrition at Northwestern University Medical School. He was picked to receive the A.M.A.'s Distinguished Service Award for 1957 for his contributions to the science of human nutrition.

To Parke, Davis & Company. The pharmaceutical firm was cited for its continuing series of ads in national magazines, "which accurately and dramatically tell the story of medicine and medical progress"-and also the facts about medical costs.

To "Dr. Hudson's Secret Journal." This TV program was cited for the way its realistic dramatic portravals build up "public esteem for the medical profession."

Approved a guide for state and county medical societies that aims at bettering their relations with the United Mine Workers' Welfare and Retirement Fund.

Among other things, the new guide insists on free choice of physician; denies that the Fund has a right to pass judgment on either the qualifications of physicians or the treatment they render: calls for remuneration of doctors on a fee-for-service basis "except under unusual circumstances," as determined by both the Fund and the local medical society; and recommends that medical society liaison committees be set up to work regularly with the Fund.

Will this guide actually lessen conflict between the country's biggest labor health plan and the private physicians it utilizes in twenty-two states? Some delegates doubt it. As Dr. Robertson Ward, a delegate from California, put it: "Doctors have accepted this guide, but the Fund hasn't!"

The fact is, Dr. Warren F. Draper, the Fund's medical officer, has told doctors he will not agree to any limitation on the Fund's prerogative to utilize physicians of its own choosing. The THE TRAL PATIENT On the go...

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WHAT YOUR DELEGATES DECIDED

Fund must retain that prerogative, he says, in order to bar unnecessary surgery, unnecessary hospitalization, and the like.

He has also spoken of using "legal means" against medical societies that deny membership to any doctors who work for the Fund. And he may have the opportunity soon. Colorado physicians—their hand somewhat

strengthened by the new A.M.A. guide—have indicated they will take disciplinary action against any doctors who work for any plan where there is no free choice of physicians.

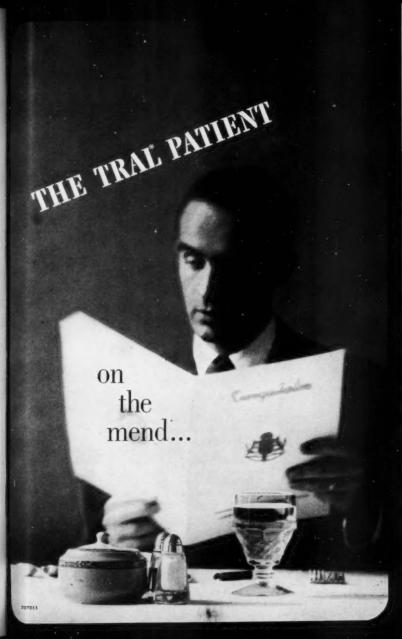
Description Objected to fixed fee schedules under the Medicare program for military dependents and urged that doctors be allowed to accept



"Not a thing, Ed. What's new with you?"

A. will nst nny ice

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WHAT YOUR DELEGATES DECIDED

Medicare payments as indemnities, not as full-service benefits, if their state medical societies so desire.

This, the delegates pointed out, would require a change in Medicare's administrative regulations but not in the law itself. The law "does not necessitate the establishment of fixed fee schedules," they noted. And they held that fixed schedules are more expensive "than if physicians were permitted to charge their regular normal fees" for professional services.

Dr. Denton Kerr of Texas sup-

plied an illustration: "In Texas, fees for a delivery ordinarily range from \$50 to \$175. Medicare in our state pays \$150. This has brought OB fees in our smaller towns up toward that level. That costs the taxpayer more."

And Dr. Richard L. Meiling of Ohio explained: "The right to set our own Medicare fees is vitally important to us because Medicare is the pilot program for all other Governmental programs in the field of medicine."

Two other major changes in Medicare had been proposed. The A.M.A. House of Delegates

PATIENTS DANCE WITH JOY

when they discover that Adolph's Salt Substitute gives real salt flavor to foods!

Adolph's Salt Substitute satisfies your patients' cravings for salt because it not only looks, sprinkles and seasons like salt, but also retains its salt flavor in cooking, baking and canning. In addition, Adolph's contains Mono-Potassium Glutamate, which accentuates the natural flavor of foods. On sale at grocery stores everywhere.

Write for free shaker samples of Adolph's Salt Substitute for your patients. Adolph's Ltd., Burbank, California.





Adolph's SALT SUBSTITUTE

THE TRAL PATIENT unbothered by the ulcer or the medicine



marked selectivity in anticholinergic therapy

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endorsed one and condemned the other. Thus:

¶It urged that anesthesiologists, pathologists, radiologists, and physiatrists be paid directly for their Medicare services. At present, the services of these specialists are paid for in accordance with local arrangements. The delegates' vote was a slap at the corporate practice of medicine.

¶It condemned a proposal that Medicare payments be made "to or on behalf of any resident, fellow, interne, or other house officer in similar status." This too represented a blow at corporate practice. Among other things, the delegates said such payments "would encourage charges by hospitals for residents' services to patients not under the Medicare program."

▶ Refused to rescind its opposition to compulsory Social Security coverage for physicians and postponed any profession-wide referendum until after an A.M.A. informational campaign.

"The burning question of So-



"This is the kind of condition you've got to operate for promptly or the patient will get better by himself."

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HOMICEBRIN

eight essential vitamins for healthy growth



DISTINGUISHED MEMBER OF THE Lilly FAMILY OF VITAMINS

control anxiety

in Arthritis, Asthma, Allergic Dermatoses

"" lower corticoid dosage

the original tranquilizer-corticoid

Ataraxoid & Productions and Androposting

provides the emotional tranquilizer, ATARAX⁵ (hydroxyzine) and the preferred corticoid, STERANE⁵ (prednisolone) • control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement • often permits substantial reductions in corticoid dosage, accompanied by reduction of hormonal side effects • confirmed by marked success in 95% of 1095 cases of varied corticoid indications¹

ATARAXOID now written a

Ataraxoid 5.0

1 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in green, scored tablets. Bottles of 30

and now available as **NEW**

Ataraxoid 2.5

2.5 mg. prednisolone, 10 mg. hydroxygin hydrochloride, in blue, scored tablets. Bottle of 30 and 100.

and NEW

Ataraxoid *1.0*

1.0 mg. prednisolone, 10 mg. hydroxysin hydrochloride, in orchid, scored tableta. Bottle of 100.

ndvantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage



1. Paragol communications

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reso dele tals, cial Security still confronts the physicians of the United States," a resolution from Connecticut doctors began. In a state-wide referendum, 73 per cent of them had voted for compulsory Social Security. They wanted the A.M.A. to change its stand.

New York doctors did too. Because of their "unfair exclusion" from Social Security, they'd have to pay \$7,000 to \$25,000 more for retirement benefits and life insurance than other citizens pay, the New York resolution said.

But it was no go. The House reaffirmed "its long-standing opposition to the compulsory coverage of physicians" and recommended an educational program among doctors to explain the reasons for the A.M.A.'s stand.

Until such a program has been carried out, the House also decided not to have the A.M.A. conduct a nation-wide referendum among doctors. This too had been urged by the Connecticut delegation.

Condemned "compulsory assessment of medical men and staff members by hospitals in fund-raising campaigns."

This action stemmed from a resolution introduced by Illinois delegates. "A certain few hospitals," they said, are promoting

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"

widely used natural, oral estrogen

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WHAT YOUR DELEGATES DECIDED

"schemes of compulsory donations... which amount to an assessment for continuation of staff appointments, thus placing such appointments on a mercenary basis..." The resolution urged that "any physician approached in such a manner report the fact to the secretary of his medical society." The A.M.A. delegates concurred.

Accepted the latest requirements for hospital staff meeting attendance as laid down by the Joint Commission on Accreditation of Hospitals. This amounted to an aboutface. A year ago, the A.M.A. delegates had resolved: "Compulsory attendance should not be required by the Commission but should be left to the discretion of the local staff."

Recently, the Joint Commission softened its rules on staff meeting attendance. They now read: "Each active staff member shall attend 50 per cent of staff meetings unless excused by the Executive Committee . . ." Total staff atendance need average only 50 per cent too.

While not quite local au-

FUNDAMENTAL THERAPY IN PEPTIC ULCER

- No alkalosis No autonomic side-effects
- No acid rebound No renal burden

AMPHOJEL

double gel for biphasic action



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"TERFORY





for prompt clinical response in many common infections especially those of the urinary and respiratory tracts

prescribe

Terfonyl Squibh Triple Sulfas Trisulfapyrimidines

- Prompt, high blood levels1
- Excellent tissue diffusion1
- Highly soluble in the urine, especially at critical pH levels¹
- Few sensitization reactions1

Tablets, 0.5 Gm., bottles of 100 and 1000.

Raspberry-flavored Suspension, 0.5 Gm. per 5 cc. teaspoonful, pint bottles.

SQUIBB



Squibb Quality-the Priceless Ingredient

TERFONYL'S IS A SQUIBE TRADEMARK

1. Lehr, D.: Modern Med. 23:111 (Jan. 15) 1955.

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MEDICAL ECONOMICS · JULY 1957 181

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tonomy, this came close enough, the delegates decided. They voted down a California resolution criticizing the Joint Commission on this count.

Other House Actions

So much for the major actions. Now for some others which may prove just as important in the long run. The A.M.A. House of Delegates also:

▶ Reaffirmed its support of the Jenkins-Keogh bill.

As the delegates described it, this bill "would permit those with self-employment income to place a small part of their earnings before taxes into a retirement fund." And they noted this hopeful sign: "More widespread interest and support for the Jenkins-Keogh legislation is evident now than ever before."

▶ Put off for further study a resolution that would direct the A.M.A. to work for "the establishment of a single national medical research fund to finance medical research into all diseases"—the fund to be administered by doctors.

The idea interested the delegates but "precipitate action was

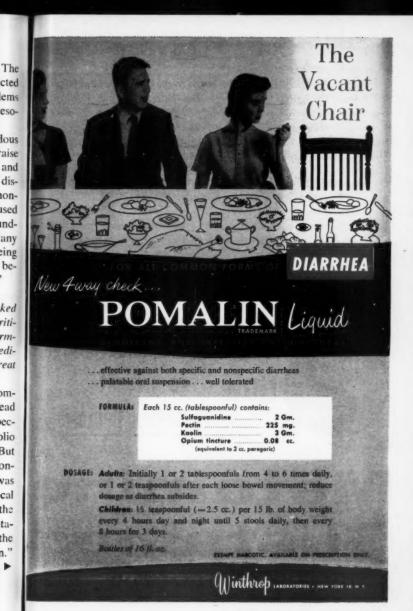
unwise," they decided. The A.M.A. Trustees were directed to study some of the problems posed in the original Ohio resolution—among them:

"There has been a tremendous increase in organizations to raise funds for medical research and care of patients with specific diseases... Too much of the money so raised of necessity is used for administration and fundraising purposes... Many important diseases are being relegated to a secondary role because of a lack of ... funds."

Disapproved a Texas-backed resolution that would have criticized the A.M.A. for not informing doctors in advance of "medical service campaigns of great national impact."

The Texas delegates complained that they'd first read about the A.M.A.'s big and spectacularly successful anti-polio campaign in the public press. But a reference committee concluded: "If the information was not disseminated to the local medical profession, it was the [fault] of the state representatives rather than that of the American Medical Association."

The House agreed. [MORE]



MEDICAL ECONOMICS · JULY 1957' 18

WHAT YOUR DELEGATES DECIDED

▶ Directed the A.M.A. to make a study of the deductions allowed for medical-care costs on Federal income-tax returns.

This action rose out of a California resolution that said: "Ever-increasing Federal and state taxes are becoming more burdensome to the average citizen... The taxpayers' expense in the maintenance of good health is given only partial recognition by taxing authorities as a deduction... Those expenses should be entirely deductible from the taxpayers' gross income as a necessary... expense."

▶ Voted down a Texas-sponsored resolution that would have placed the A.M.A. in opposition to Federal subsidies for medical school construction.

Instead, the delegates reaffirmed their support of "one-time matching Federal grants for construction of medical educational facilities."

► Voted down—amid wry laughter—another Texas-sponsored resolution that would have placed the A.M.A. on record as favoring repeal of the Federal income-tax law. [MORE ►



Simplified dosage* to prevent Angina Pectoris

Metamine of Triethanolamine trinitrate biphosphate, LEEMING, 10 mg. Sustained

*Usual dose: Just 1 tablet upon arising and one before the evening meal. Bottles of 50 tablets. Thos. Leeming & Co., Inc., 155 East 44th Street, N.Y. 17, N.Y. 184 MEDICAL ECONOMICS: JULY 1957

My patients complain that the pain tablets I prescribe are too slow-acting... they usually take about 30 to 40 minutes to work.

Why don't you try the new codeine derivative that's combined with APC for faster, longer-lasting pain relief?

CLINICAL

What is it... how fast does it act?

It's Percodan^o—relieves pain in 5 to 15 minutes, with a single dose lasting 6 hours or longer.

How about side effects?

No problem. For example, the incidence of constipation with Percodan' is rare.

Sounds worth trying — what's the average adult dosc?

One tablet every 6 hours. That's all.

Where can I get literature on Percodan? Just ask your Endo detailman or write to:



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*U. S. Pat. 2,628,185. PERCODAN contains salts of dihydrohydroxycodeinone and homatropine, plus APC. May be habit-forming. Available through all pharmacies.

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antibacterial effectiveness for 24 hours on a single (1 Gm.) dose

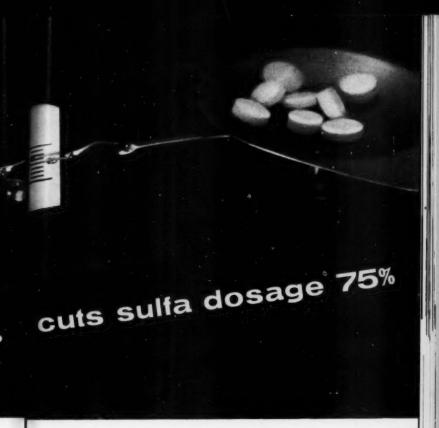
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LOW D RAPID

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GREAT cretion



KYNEX Sulfamethoxypyridazine is a completely new, long-acting single sulfonamide with clinical advantages hitherto unequaled in sulfa therapy -

LOW DOSAGES - only 2 tablets per day.

RAPID ABSORPTION: — therapeutic blood levels within the hour, blood concentration peaks within 2 hours.

PROLONGED ACTIONS - 10 mg. per cent blood levels that persist over 24 hours on a maintenance dose of 1 Gm.

BROAD - RANGE EFFECTIVENESS — particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, paracolon bacilli, streptococci, staphylococci, Gram-negative rods, diphtheroids and Gram-positive cocci.

GREATER SAFETY - high solubility, slow excretion and low dosage help avoid crystalluria. No increase in dosage is recommended; the usual precautions regarding sulfona-mides should be observed.

CONVENIENCE — the low maintenance dosage of 1 Gm. (2 tablets) per day for the average adult offers optimum convenience and acceptance to patients.

Each quarter-scored tablet contains: sulfamethoxypyridazine ... 0.5 Gm. (71/2 grains). 1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.; Antibiot Med. & Clin. Ther. 3:378 (Nov.) 1956.

Aqueous - readily NOW AVAILABLE

miscible Caramel flavored

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Stable - no refrigeration needed · Readily acceptable by

patients of all ages Each teaspoonful (5 cc.) of KYNEX Syrup contains 250 mg. sulfamethoxypyridazine.

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WHAT YOUR DELEGATES DECIDED

A reference committee said the resolution did "not deal with a matter of primary medical concern." And the other delegates concurred.

Asked the A.M.A. to improve its liaison with the radio and television industry so as to eliminate "offensive or misleading advertising" of drugs.

Such advertising was said to be inviting radio and video audiences to treat themselves. Thus it was causing "irreparable harm to the general population," the delegates resolved. ▶ Renewed its support of the World Medical Association and recommended that all A.M.A. members join its United States supporting committee.

Although the World Medical Association aims at protecting the freedom of medicine and beefing up the influence of the medical profession at the international level, only some 5,000 American doctors now support it. It's "difficult to believe" that many times that number don't "wish to share in this international effort," the delegates said, in urging more M.D.s to join. END

new concept! COLORIMETRIC test for proteinuria



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REAGENT STRIPS

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CONVENIENT ACCURATE TIMESAVING available: ALBUSTIX Reagent Strips—Bottles of 120.



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AMERICAN STOMACH

- Acid distress
- Heartburn

- Dyspepsia
- Peptic ulcer

for the hyperacidity that is so common on the American scene, ALUDROX gives acid-hungry therapeutic action without systemic penalties. ALUDROX combines reactive alumina gel with milk of magnesia in a rational proportion of 4:1. It is a balanced formula for prompt relief, soothing action, and healing powers—without constipation, acid rebound, or alkalosis.



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SUSPENSION

ALUDROX

Aluminum Hydroxide with Magnesium Hydroxide to neutralize, not penalize



Philadelphia 1, Pa.



What You Can Learn ron

You can detect signs of financial strength or weakness in the figures put out by any business concern or medical organization. Here's how

By Thomas Owens

All well-run organizations that handle money—business firms, medical societies, hospitals, etc.—describe their dollar operations by means of (1) an income statement and (2) a balance sheet. An income statement is a moving picture of financial activities over a period of time. A balance sheet is a still photo of financial conditions on a given date.

As a physician, you're bound to be confronted with such financial statements from time to time. And if you're a typical physician, your reaction's likely to be "What's the meaning of it all?"

This article and a subsequent one are intended to answer that question. They'll show you, by means of a simple line-by-line analysis, how to read meaning into what appears at first sight to be merely accounting jargon and a jumble of figures. In this article we'll take a typical balance sheet, break it down into its component pieces, and see what each reveals. Next month we'll do the same with an income statement.

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The balance sheet we're examining is shown on pages 194-195. You'll notice that each item on it has been given a number. This is merely to help you recognize each item as it's explained later on in the text.

Take a look now at the total figures shown at the very bottom of our sample balance sheet. The first thing you'll probably notice is that assets exactly equal liabilities. They always do. Here's why:

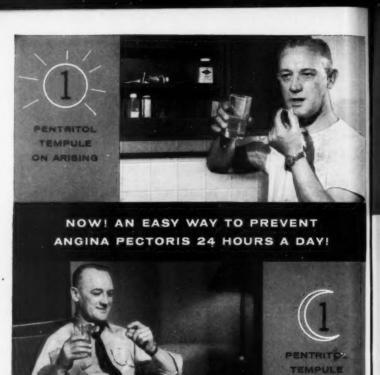
When true liabilities (debts) are subtracted from assets, the difference is also listed in the liability column, making a balance inevitable. This difference is called *net worth*—or *stockholders' equity*. It consists of the par or stated value of stock issues, surplus, and reserves created from surplus.

The point to remember is this: Though the total figures on every balance sheet always balance, it's the degree and nature of the *un*balance in various parts of a balance sheet that reveal the financial strength of the organization concerned.

For example, note the unbalance between the Mythical Manufacturing Company's current assets of \$8,946,000 (item 6) and its current liabilities of \$1,562,000 (item 19).

Current assets divided by current liabilities give you what's called the *current ratio*. In this case it's better than

1



Why prevent Angina Pectoris only part of the time when you can easily prescribe continuous prevention with Pentritol Tempules. In a recent clinical study (soon to be published) the effect of Pentritol's 24-hour vasodilation was observed. Over 90% of patients reported:

- 1. Nitroglycerine requirements reduced;
- 2. Pain reduced or eliminated;
- 3. Fewer or no attacks;
- 4. Work capacity increased.

These results show the effectiveness of Pentritol's 24-hour vasodilation.

Samples and literature on request.

PENTRITOL

in the EVENING

Tempules

Timed disintegration capsules containing 30 mg. pentaerythritol tetranitrate (PETN) controlled to release three 10 mg. doses which provide 12 hour coronary vasodilation.

The Evron Company, 3540 Clark, Chicago 13, III.

192 MEDICAL ECONOMICS : JULY 1957

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Growing use of the ECG in cardiovascular work means more locations in which 'cardiograms are being run: in your office...at your patient's home...in hospital heart stations, laboratories, wards. This immediately focuses attention on instrument portability—and the obvious value of the new Sanborn Model 300 Visette.

For the first time—in "brief case" size—is everything needed to take a 'cardiogram of full clinical accuracy. This remarkable new transistorized direct writer incorporates all the best features of earlier Sanborn instruments developed over the past 33 years—plus extremely light weight (18 pounds) and small size (12¾" x 10½" x 5¾") made possible by original design and modern electronic components. New in the "300", too,

are such operating advantages as fully automatic, "one hand" Instomatic action; automatic "push button" grounding; even simpler chart loading; and interlock switch to prevent closing cover with power on.

The doctor with the active cardiac practice will particularly appreciate these Visette features; but wherever this modern ECG is used, "convenience" will be the characteristic by-word. Ask your Sanborn Representative for full Visette information, and a demonstration in your office, of this modern, moderately priced instrument.

The established Sanborn Model 51 Viso-Cardiette is still available for those who prefer a larger, heavier (34 lbs.) instrument - \$785.

delivered.

18 lbs.

TRANSISTORIZED
\$625 del.

SANBORN COMPANY

The Mythical Manufacturing Company, Inc. Consol

	Assets	
ITE		
1	CURRENT ASSETS:	0 0 0 0 1 0 0 0
2	Cash	\$ 2,254,000
3	U. S. Government Securities	1,371,000
4	Accounts Receivable (less reserve)	2,856,000
5	Inventories (at lower of cost or market).	2,465,000
6	TOTAL CURRENT ASSETS	\$ 8,946,000
7	INVESTMENT IN AFFILIATED COMPANY—	
	Not consolidated (at cost, not in excess of	
	net assets)	234,000
8	OTHER INVESTMENTS (at cost, less than	
	market)	126,000
9	SINKING FUND	550 000
10	PROPERTY, PLANT, AND EQUIPMENT:	
	Cost	
11	Less Reserve for Depreciation 5,246,000	3,285,000
12	PREPAYMENTS	52,000
13	Deferred Charges	121,000
14	PATENTS AND GOODWILL	165,000
	TOTAL	\$13,479,000

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FIRST 31/2 RESE STOC

y, Inc_{Cons}olidated Balance Sheet, December 31, 1956

Liabilities

The state of the s	
CURRENT LIABILITIES:	
Accounts Payable	\$ 361,000
Accrued Taxes	829,000
Accrued Wages, Interest, and	
Other Expenses	372,000
TOTAL CURRENT LIABILITIES	\$ 1.562,000
FIRST MORTGAGE SINKING FUND BONDS,	
3½% Due 1972	2,154,000
RESERVE FOR CONTINGENCIES	250,000
STOCKHOLDERS' EQUITY:	
Contributed Capital	
Capital Stock:	
5% Preferred Stock (authorized	
and issued 10,000 shares of	
\$100 par value)\$1,000,000	
Common Stock (authorized and	
issued 400,000 shares	
of no par value) 1,000,000	2,000,000
Capital Surplus	1,900,000
Earned Surplus	5,613,000
TOTAL	\$13,479,000

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WHAT A BALANCE SHEET TELLS YOU

five to one; that is, the company's current assets cover its current liabilities more than five times over. The implication is that the concern certainly isn't in danger of going broke in the near future.

For current liabilities are simply debts that will fall due within the next year, and current assets are the funds that will be available to meet them (cash, or securities that can be turned into cash quickly, plus assets that will be converted into cash in the ordinary course of business).

What constitutes a strong current ratio? Certainly five to one isn't bad. But what about three to one? Or two to one? Or less?

Financial men generally cast a fishy eye on a ratio of less than two to one. Beyond that, much depends on the kind of business the company is in. In recent years leading chemical concerns have shown ratios of around three to one; tobacco companies, four to one; railroads, two to one. To judge the current ratio of a company, compare it with the current ratios of other similar companies in the same industry.

Another measure of the strength of an organization is to be found in its quick assets—current assets less inventories. For the Mythical Manufacturing Company they amount to \$6,481,000, or more than four times the current liabilities. This is a good sign. Current assets The general rule is that quick assets should at least 11 Liabilities equal current liabilities.

> The difference between current assets and current liabilities is called working capital-\$7,384,000

> in the case of our sample company. Many investment analysts believe that an industrial concern

Current Ratio 1,562,000 18,946,000 Current Current Liabilities assets

= Working Capital

Under suspicion of anemia

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TRINSICON.

(Hernatinic Concentrate with Intrinsic Factor, Lilly



2 a day for all treatable anemias





In menorrhagia . in geriatrics . in pregnancy . in adolescence

Lilly
OUALITY / RESEARCH / INTEGRITY

- serves a vital function in your total therapy

'Trinsicon' provides therapeutic quantities of all known hematinic factors, offers maximum absorption and tolerance.

Just two pulvules daily also produce a standard response in the average uncomplicated case of pernicious anemia and related megaloblastic types.

Daily dose (2 pulvules) of 'Trinsicon' provides:

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor) . 300 mg.

Vitamin B_{12} with Intrinsic Factor Concentrate, U.S.P. . . 1 U.S.P. unit (oral)

Vitamin B₁₂ Activity
Concentrate, N.F. 15 mcg.

Ferrous Sulfate, Anhydrous . . . 600 mg.

 These three ingredients are clinically equivalent to 1½ U.S.P. units of APA potency.

Equal to over 1 Gm. Ferrous Sulfate, U.S.P.

note: Special Liver-Stomach Concentrate, Lilly, supplies, in addition to intrinsic factor, natural compounds that provide broad nutritional support in the treatment of all types of anemia.

In bottles of 60 and 500.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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WHAT A BALANCE SHEET TELLS YOU

should have a working capital at least equal to the face value of its outstanding bonds and preferred stocks. Mythical's working capital is 2.3 times the stated value (\$3,154,000) of its bonds and preferred stocks.

2 Cash	S	2,254,000
3 U. S. Government Securities	*	1,371,000
Accounts Receivable (less reserve)		2,856,000



Now take a closer look at current assets. The figures for cash and U. S. government securities may be considered as above suspicion if the company's financial statement has been checked by a firm of certified public accountants.

Note that the value of accounts receivable is given only after prior deduction of a reserve for bad debts. We don't know how much this reserve is. But at least it's clear that the company isn't proceeding on the starry-eyed assumption that it will suffer no credit losses.

S Inventories (at lower of cost or market)	2,465,000



Of all current assets, inventories are worth the closest look. Their size and the way they're valued has a lot to do with the profits or losses the company will show later.

The accepted and conservative way to value inventories is as Mythical has done—at whichever figure is lower: the price the company paid for its inventory materials, or the price such materials

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200 MEDICAL ECONOMICS - JULY 1957



a way of escape from allergic effects of pollen

RONIL

(Pyrrobutamine Compound, Lilly)

-with minimal side-effects

This is the season when we all yearn for escape from everyday life, to "commune with nature." But, to the one allergic to pollen, this craving is usually easier to endure than the penalty of exposure to pollen.

Such a patient is grateful for the relief and protection provided by 'Co-Pyronil.' Frequently, only two or three pulvules daily afford maximal beneficial effects.

'Co-Pyronil' combines the complementary actions of a rapid-acting antihistaminic, a long-acting antihistaminic, and a sympathomimetic.

(Pyrrobutamine, Lilly) 25 mg. 'Histadyl' (Thenylpyramine, Lilly) 'Clopane

Each Pulvule 'Co-Pyronil'

15 mg.

provides: 'Pyronil'

Hydrochloride' 12.5 mg. (Cyclopentamine Hydrochloride, Lilly)

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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currently bring in the open market. Thus, it might list some materials at the first figure, others at the second.

Are the company's inventories top-heavy? Has it stocked up on a lot of goods on which it may take a loss if a recession comes along?

You can get some idea on this by dividing the inventory figure into the company's cost-of-goodssold figure (found in its income statement). Suppose the result, called inventory turnover, is five. How does this figure compare with that of other companies in the same industry?

If it's much too low, taken against the average, the company may be sticking its neck out, overcommitting itself in inventories. If it's far too high, this may mean the outfit is living from hand to mouth on raw materials; it might get stuck in case of shortages or strikes by its suppliers.

Now for the other assets:



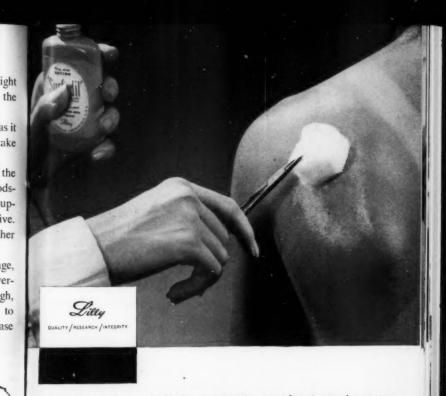
First is a \$234,000 investment in an affiliated company. We don't know what the investment is worth today; only what was paid for it. But the phrase "not in excess of net assets" suggests that the purchase price was a reasonable one in the light of the affiliated company's own balance-sheet position (net assets being those available for stockholders after deduction of all creditors' claims).

Chances are that Mythical holds less than 50 per

Lotio

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Abates pain and itch, protects against sun's rays
LOTION

SURFADIL

(Cyclomethycaine and Thenylpyramine, Lilly)

Formulated to insure patient acceptance

Lotion 'Surfadil' is available in an attractive plastic container (75 cc.) at retail pharmacies everywhere. Also supplied in 1-pint bottles and as a cream in 1-ounce tubes and 1 and 5-pound jars.

Lotion 'Surfadil' combines the highly effective topical anesthetic, 'Surfacaine' (Cyclomethycaine, Lilly); an antihistamine, 'Histadyl' (Thenylpyramine, Lilly); and the protective adsorbent, titanium dioxide. It provides prompt and prolonged relief from contact dermatitis caused by poison ivy, oak, or sumac. It is also valuable for eczema, insect bites, heat rash, and sunburn.

Lotion 'Surfadil' is skin tone in color and virtually odorless; does not readily rub off but washes off easily.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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Mythical owns less than 50% of of affiliated Subsidiacy company companies

cent control of this other company. Otherwise Mythical would class it as a subsidiary and include all the company's assets and liabilities in the Mythical balance sheet. It has already done this with other subsidiaries. That's why its balance sheet is labeled "Consolidated."

It's also apparent that Mythical owns 100 per cent of the stock of these subsidiaries. Otherwise, the consolidated balance sheet would show under liabilities the item "Minority Interest," representing the equity of other stockholders in the subsidiaries.



The next item, "Other Investments," presumably consists of miscellaneous stocks and bonds. Why not carry them as current assets? It's more conservative not to, since their market isn't so reliable as that for government bonds. Also, Mythical may intend to hold them more or less permanently, as it probably does its investment in the affiliated company; if so, tagging them as current assets would be doubly misleading. "At cost, less than market" means that the company has a paper profit on them.



The company's "Sinking Fund" is also probably invested in securities. Sole purpose of this fund is to pay off the company's bonds (shown on the liability side of the balance sheet), which fall due



204 MEDICAL ECONOMICS - JULY 1957

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for a quick comeback

a powerful therapeutic weapon

Particularly in nonhospitalized patients, no single or combination antibiotic can outperform 'V-Cillin' in eradicating a majority of common infections. Its bactericidal action under clinical conditions generally remains unsurpassed.

Supplied: As pulvules of 125 and 250 mg. (200,000 and 400,000 units) and pediatric suspensions of 125 and 250 mg. per 5-cc. teaspoonful.

Compares favorably with parenteral therapy On the basis of total penicillemia, 'V-Cillin' in dosages of 250 mg. t.i.d. is at least equal to a daily I.M. injection of 600,000 units of procaine penicillin G. Therapeutically, these two regimens are comparable.

Safe, pleasant, well tolerated

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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fifteen years hence. This is a very common reason for setting up a sinking fund.

Under an agreement it made when it sold these bonds to the public, the company was required to set up such a fund and add to it each year. Failure to do so, like failure to pay interest, would probably throw the company into bankruptcy. The bondholders have the further protection of a first mortgage on all the company's fixed assets—an advantage that stockholders don't get.

P	ROPERTY, PLANT, AND EQUIPMEN	NT:	
	Cost		
11	Less Reserve for Depreciation 5	,246,000	3,285,000

Fixed assets is simply another term for what, on the Mythical balance sheet, is labeled "Property, Plant, and Equipment." Note that these are carried at cost, less a reserve for depreciation. This depreciation reserve is, in effect, a hole in the assets.

Failure to charge depreciation would give a false statement of earnings, since the company would be living partly off its own fat. (Similar to depreciation are charges for depletion by companies that operate mines or oil-producing lands.)

(12	PREPAYMENTS	52,000
63	DEFERRED CHARGES	121,000
-		5

"Prepayments" and "Deferred Charges" both represent money the company has paid out for services or benefits yet to be received. Rent or insurance premiums paid in advance are an example of pre-



Dose

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Avail

solu and

ELI



when infection strikes the respiratory tract . . .

ILOTYCIN

provides singularly effective antibiotic therapy because

Dosage: The usual adult dose is 250 mg. every six hours.

Available in specially coated tablets, pediatric suspensions, drops, otic solution, ointments, and I.V. ampoules.

- · Virtually all gram-positive organisms are sensitive
- · Allergic reactions following systemic therapy are rare
- Bactericidal action kills susceptible organisms
- · Normal intestinal flora is not appreciably disturbed

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

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payments. A typical deferred charge would be the development costs of a product not yet ready for market.

Instead of treating such costs as an expense of the year they're incurred, the company will prorate them over several future years when the product is actually on sale. Meanwhile, believing these expenditures are a valuable investment for the future, it carries them on the asset side of the annual balance sheet.



In reading any balance sheet, remember that many of the figures do not reflect "true value"—i.e., what the items would bring if offered for sale. An example is fixed assets, commonly listed at cost (which is ancient history) less depreciation (a pure estimate).

An even better example is "Patents and Goodwill," often called intangibles. Clearly these items are worth something. But how much?

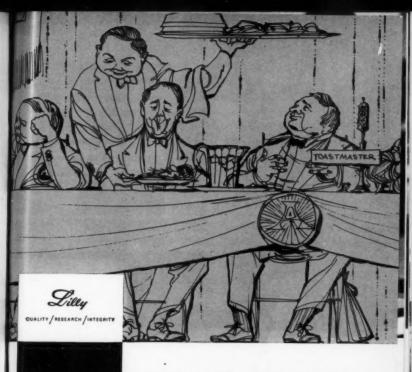
Some companies that own important patents and trademarks nevertheless exclude such items from their balance sheets—or value them at a nominal \$1. Examples: Reynolds Tobacco (Camels), Procter & Gamble (Ivory Soap), Montgomery Ward, U. S. Steel.

On the other hand, the American Tobacco Company (Lucky Strikes) values its intangibles at \$54,-000,000; Coca Cola, at \$39,000,000; du Pont, at \$42,000,000.

The point is that the value of intangibles depends

Value of goodwill?

Usual grains Availa grain pharm



relieves after-eating distress
...chronic constipation

BILRON

(fron Bile Salts, Lilly)

a physiological choleretic

Usual dosage: 5 to 10 grains daily with meals.

Available in 2 1/2 and 5grain tasteless pulvules at pharmacies everywhere. ... greatly increases the flow of bile of normal composition. 'Bilron' is acid insoluble and alkali soluble; therefore, it becomes physiologically active in the intestine, where bile is normally released. Gastric irritation is thus averted.

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ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U. S. A.

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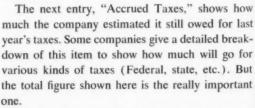
on individual circumstances that can't always be accurately estimated. That's why they're customarily left out of the picture in computing the *book value* of a company's securities.

The book value of a corporation's outstanding securities is the money that would be available to pay them off, after first paying off all senior claims, if the company's tangible assets were sold at prices equal to the figures established as their book (balance sheet) valuations.

Before we can compute this book value, we have to consider the liability side of the balance sheet. Note that the first item listed is "Current Liabilities." This includes all outstanding bills that the company owed on December 31.

CURRENT LIABILITIES:	\$ 361,000
Accrued Taxes	829,000
Accrued Wages, Interest, and Other Expenses	372,000
TOTAL CURRENT LIABILITIES	\$ 1,562,000

"Accounts Payable," for example, represents the amount owed for raw materials, supplies, etc., to other firms.



Listed with current liabilities, too, is the amount



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QUALITY / RESEARCH / INTEGRITY

release from anxiety
without impairment of mental acuity
or physical skills

ULTRAN

(Phenaglycodol, Lilly)

Exhaustive psychological testing shows that the usual range of dosages does not interfere with normal intellectual or motor abilities. This has been established by objective and standardized quantitative tests.

Anxiety quickly allayed

The patient with vague symptoms, nervous and distressed under the burden of unsolved problems, finds release from anxiety and restoration of emotional composure.

Chemically unique

 ${}^{\prime}$ Ultran' is not a modification of any other therapeutic agent.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S.A.

774087

XUM

Dosage: Usually

attractive turquoise-

and-white pulvules of 300 mg.

1 pulvule t.i.d.

Supplied: As

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owed, as of December 31, for employes' wages, for bond interest, and for such expenses as fees to attorneys, etc.

Next on the liability side of the balance sheet, the company reports that it has a bond issue falling due in 1972. Suppose you were interested in buying some of Mythical's bonds. First question you want answered: What's the book value of each bond—or, in other words, how much money would there be available to pay off bondholders in the event the company dissolved? Here's how you figure that out:

Mythical has 2,154 bonds outstanding, each of \$1,000 face value. Its tangible assets (\$13,314,000) less its current liabilities (\$1,562,000) leave \$11,-752,000 to pay off the bonds. Dividing this figure by 2,154, we find that each bond is backed by \$5,456 worth of assets.

5,456 per 1,000 \$5,456 per 1,000 bond 11,752,000 Number Net assets bonds

In actual liquidation, of course, each bond would be entitled to only \$1,000. The \$5,456 figure merely indicates the margin of safety that the bondholders enjoy—and in this case, as you can see, it's an ample one.

Book value of other securities is computed the same way. But the book value of a common stock has limited bearing on its market value. Common stock prices generally respond more to earnings-and-dividends prospects; they ignore book values as academic.



Sturdy, large gauge permanent aspirating tip pierces toughest vial diaphragm, withdraws solution easily.

This unique VIM design permits easy, complete withdrawal of even the most viscous solution — ends bending, breaking, dulling of hypodermic needles because only aspirating tip pierces vials' rubber seal — greatly increases needle life.



A quick twist locks injecting needle on aspirating tip. Either VIM Stainless or VIM Laminex needles may be used.



Gabriel Aspirating Syringe

Available through your surgical/hospital supply dealer or write:

MacGregor Instrument Co., Needham, Mass.

MEDICAL ECONOMICS · JULY 1957 213

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Exceptions are the shares of banks, insurance companies, and investment trusts. Their assets, instead of being factories or railroad lines of unknown auction worth, are mostly cash and securities, subject to accurate valuation. Here book value is some indication of true value, and the market pays it some attention.



RESERVES

Under liabilities, Mythical also lists a "Reserve for Contingencies." This money actually represents part of the common stockholders' stake in the company, but it's not currently available for payment of dividends.

Setting up such a reserve is merely an accountant's way of saying: "We mustn't think of our surplus as being as big as it really is. Let's set part of it aside in recognition of some of the nasty things that could happen to us." So they lop \$250,000 off the surplus account and call it a reserve.

23 STOCKHOLDERS' EQUITY:

Contributed Capital

23 Capital Stock:

5% Preferred Stock (authorized and issued 10,000 shares of \$100 par value) ...\$1,000,000

Common Stock (authorized and issued 400,000 shares of no par value) ... 1,000,000

Spoital Stus ... 1,000,000 2,000,000

All the remaining items on the liability side of the balance sheet come under the general heading of

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that eau be expe slus dramatic relief wrethral symptoms (often provided by to. 10 tak three actions 1 6 au alre against urinary infections. in one tablet: Om Jane (1) systemic antibacterial action act (2) local antibacterial action Ti (3) local analgesic action AZO GANTRISIN ROCHE! Since Cantrisin has both autibactereal action, Azo Ga us both ascending and clesce XUM

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AZO GANTRISIN ROCHE

antibacterial—analgesic
clears urinary tract infections
—relieves pain

Each Azo Gantrisin tablet contains 0.5 Gm Gantrisin plus 50 mg of phenylazo-diamino-pyridine HCl.

The prompt antibacterial action of Gantrisin is both systemic and local, and is directed against a wide range of pathogens—including E. coli, B. proteus, and Pseudomonas. The high blood and urine levels of Gantrisin promptly clear descending and ascending urinary tract infections.

The specific local analysis resulting from phenylazo-diamino-pyridine HCl relieves burning, urgency, and nocturia — often within 2 hours.

Your patient will know that your therapy is working soon after taking the first Azo Gantrisin tablet: he will see evidence of the drug in the orange colored urine; he will feel less pain.

Dosage: Adults and children over 100 lbs - 2 tablets, q.i.d. Children under 100 lbs - 1 tablet, q.i.d.

Supplied: Red, monogrammed tablets in bottles of 100 and 500.

Gantrisin®-brand of sulfisoxazole

ROCHE

HOFFMANN - LA ROCHE INC

NUTLEY

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NOTABLE QUOTES about **CLISTIN** in Allergy

"Carbinoxamine maleate produced the fewest complaints of drowsiness, as well as the lowest incidence of all side effects . . . "1

. compares favorably with the most effective antihistaminic agents now available . . . produces less sedation than most ..."2

"Undesirable side effects ... were infrequent and usually mild in nature."3

"87 per cent reported some relief of their symptoms ... "3

"Clistin has proved to be useful in the relief of symptoms caused by perennial allergic rhinopathy and in acute and chronic urticaria and pruritus."4



"Clistin Maleate is a potent antihistaminic drug with only weak sedative properties ... "2

CLISTIN

McNEI

LABORATORIES, INC. Philadelphia 32, Pa.

Dosage forms:

Tablets Clistin, 4 mg. Tablets Clistin R-A (Repeat Action Tablets Clistin, 8 mg.) Elixir Clistin, 4 mg. per 5 cc.

- MacLaren, W. R., Bruff, W. C., Eisenberg, B. C., Weiner, H., and Martin, W. H. Ann. Allergy 13:307 (May-June) 1955.
 Beale, H. D., Rawling, F. F. A., and Figley, K. D.: J. Allergy 25:521 (Nov.) 1954.
 Johnson, H. J., Jr.: Am. Pract. & Digest. Treat. 5:862 (Nov.) 1954.
 Garat, B. R., Landa, C. R., Rossi Richeri, O. F., and Tracchia, R. O.: J. Allergy 27:57 (Jan.) 1956.

MEDICAL ECONOMICS · JULY 1957

"Stockholders' Equity." This term covers capital stock and surplus.

Note that on the Mythical balance sheet "Capital Stock" includes both common stock and preferred stock. A company may have many kinds of stock outstanding-preferred, prior preferred (ranks ahead of other preferred issues), class A, class B (usually signifies a difference in voting powers), common stock, founders' shares, etc.-but the generic term is capital stock.

Essentially, any kind of stockholder is a joint owner of the company. A bondholder is a creditor; he's merely loaned the company money, not bought an interest in it.

Preferred stock is so called because it has first call on dividends. Mythical can't pay anything to its common stockholders unless it first pays the full annual rate (\$5 per share) to holders of the preferred. Often, in lean years, preferred stockholders get paid and common stockholders don't.

When times get too lean, the company may quit paying preferred stockholders too. They can't toss the company into bankruptcy for this (as bondholders can if they don't get their interest). But preferred dividends are often cumulative. This means that, before the company can start paying its common stockholders again, it must settle up all dividend arrears on the preferred stock. And, if the company decides to liquidate, preferred stockholders usually get paid off (up to the par value of their shares) ahead of the common stockholders-who get what's left, if anything.

But preferred stockholders usually can't be paid



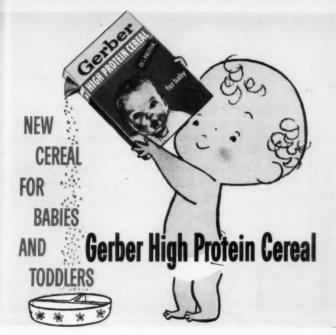
216 MEDICAL ECONOMICS - JULY 1957

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Availab	le Carbohydrate-	
Ву	Difference	48.74
Crude I	iber	1.48
Ash-M	linerals	7.26
	Ash Includes	
	Calcium	0.859
	Phosphorus	0.930
	Iron	0.050
Moistur	e	5.87

Calories Per Ounce 99 One ounce supplies the following proportions of the minimum daily requirements for nutrients.

		FOR YOUNG
	OR INFANTS	CHILDREN
Thiamine	320%	160%
Riboflavin	120%	0.6 Mg.*
Niacin	4 Mg.*	4.0 Mg.*
Calcium	246 Mg.	32%
Phosphorus	265 Mg.	35%
Iron	14 Mg.*	187%
*Minimum	daily requi	rements for
these nutrie	ents have no	been estab-

lished for the ages indicated.

Exceptional nutritive value. Gerber High Protein Cereal is a new baby cereal, designed to increase the protein intake of babies and young children. The high total protein content (35%) combines proteins from oats, wheat, soy beans and yeast. In combination, these vegetable proteins are utilized most efficiently-and offer the mother an economical way to provide protein in easy-to-digest form. For further nutritive value, the High Protein Cereal is fortified with iron, calcium and B-vitamins.

Gerber High Protein Cereal has a toasted, nutlike flavor that is well accepted by babies and remains interesting to toddlers and young children. It also provides appetizing variety when rotated with Gerber Rice Cereal, Barley, Oatmeal and Cereal Food (a mixed cereal). Like all Gerber Baby Cereals, the new Protein Cereal is pre-cooked and ready to serve with milk, formula or other liquids.

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MEDICAL ECONOMICS · JULY 1957 217

more than their fixed dividend rate. For common stockholders, the sky's the limit. That's why, when a company prospers, common stockholders may do a lot better than preferred holders. Also, they have voting control of the company-unless it falls behind on preferred dividends. (Then there may be a provision for preferred stockholders to take over.)

The \$1,000,000 figure that Mythical places opposite its preferred stock is logical enough (because the 10,000 preferred shares are entitled to \$100 each in liquidation). But the \$1,000,000 for the common stock is virtually meaningless.

Dividing 400,000 into \$1,000,000, we know that the stated value of the stock is \$2.50 per share. But stated value is merely a figure the company picks out of the air. Actually, it sold the stock originally for an average of \$7.25 a share.

24 Capital Surplus 1,900,000 25 Earned Surplus 5,613,000

The last two items on the balance sheet show the company's surplus. All surplus is reserved to the common stockholders. The part marked "Capital Surplus" came from selling shares in excess of their stated value. The part marked "Earned Surplus" represents accumulated profits in excess of what have been paid out in dividends over the years.

Why separate earned surplus from capital surplus? Because, if they were lumped together, a balance-sheet reader might easily assume that the company had earned and saved the whole amount. Also, companies do not ordinarily pay dividends

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invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes... Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation. for 4 full hours... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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Ephedrine HCl	3/8 gr.
Phenobarbital	1/8 gr.
in boxes of 24, 120 and 1000	tablets

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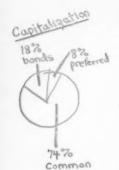
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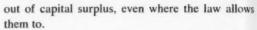
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Worth noting in any corporate balance sheet is the proportion of each class of security to the total capital structure (bonds, preferred stock, common stock, contingency reserve, and surplus). For Mythical, the bond ratio (\$2,154,000 of bonds divided by \$11,917,000 total capitalization) is 18 per cent; the preferred stock ratio, 8 per cent; the common stock ratio, 74 per cent.

This is a reasonably conservative capital set-up for an industrial company.

Financial men generally consider a bonded debt of more than 25 per cent of total capitalization excessive in such cases. Also, they feel that bonds and preferred stocks combined should not represent more than 50 per cent. But railroads and utilities are permitted somewhat higher senior-security ratios. Generally speaking, the smaller the common stock ratio, the more speculative the investment quality of the company.

A corporation balance sheet, like Mythical's, is not essentially different from that of a medical society or a partnership. But the latter, while it might have bonds outstanding, would not have stock.

What does a balance sheet really show? If the company is in sound financial health, that much should be apparent; if it's teetering on the edge of the grave, that should be evident too.

But to tell whether its health is improving or declining, you must also have a look at the company's income statement. Next month I'll describe some of the things you can learn from that. END







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PHOSPHO[®] SODA (Fleet)...

gentle, prompt, thorough and a laxative of choice for over 60 years.

Taken on an Empty Stomach...

at least 30 minutes before any meal, but preferably before breakfast.

Amply Diluted with Water...

Mix required dose with one half glass of cold water, follow with additional water.

SUGGESTED DOSAGE As a mild eliminant, two teaspoonfuls before a meal. For more pronounced hydragogue action, four teaspoonfuls before breakfast.

Children: Ten years or older, one half the adult dose; five to ten years, one quarter the adult dose.

Phospho-Soda (Fleet) is a solution containing per 100 cc., Sodium Biphosphate 48 Gm. and Sodium Phosphate 18 Gm.

In preparing for colonic surgery, preoperative administration of neomycin plus cleansing with Phospho-Soda (Fleet) suppresses intestinal bacteria.(1)

(1) Davis, J. H. et al., Surgery, 35:434, 1954



(Fleet)

C. B. Fleet Co., Inc., Lynchburg, Virginia Makers of the Fleet Denma Disposable Unit.

MEDICAL ECONOMICS · JULY 1957 221

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3. The Effect of Your Refresher Work

EDITOR'S NOTE: Apparently most of us have been cherishing some false notions about the type of training, experience, and practice methods that help to make a doctor good. This conclusion emerges from a pioneering study sponsored recently by the Rockefeller Foundation. Though the study was intended solely as an appraisal of general practice—and of the type of training most likely to turn out competent G.P.s.—it's of interest to every doctor, no matter what his field. This article is the third of several summing up the study group's findings.

If you're really interested in your work, you're likely to do well at it. And because you want to do well, you probably attend a good many medical society and hospital meetings, take periodic refresher courses, and read a number of professional journals.

Your diligence is commendable—but it may do you less good than you think.

In a report published recently by the Association of American Medical Colleges, a study team from the University of North Carolina concludes that the typical doctor isn't likely to gain much from the post-graduate courses available to him. What's more, medical society

ood Doctors Get That Way?

By Lois Hoffman

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and hospital meetings don't seem to improve his clinical skill. Only the number of journals he reads regularly appears to bear a direct relation to how good a doctor he is.

These findings—like the ones reported in previous articles—may suggest changes you'll want to make in your professional life, whatever your field of practice.

The North Carolina researchers started by evaluating the clinical skills of eighty-eight family doctors. Then they assigned each man to one of five ranks designated by Roman numerals. V represented a top performance, III "average," and I the lowest level, with IV and II intermediate ranks. (When these are converted into Arabic figures, 3.0 becomes the middle rank and anything higher becomes better than average.)

Last month I described the extent to which these clinical rankings reflected the G.P.s' medical school and hospital training records. The most significant findings:

¶ Men who'd been in the top third of their class and were under the age of 36 had an average clinical rank of 4.2. They ranked higher than any other scholastic or age group.

¶ The longer the hospital training in internal medicine,



When

Temptation

takes him in tow . . .



24 MEDICAL ECONOMICS - JULY 1957

GOOD DOCTORS

the better the doctor. Men with more than eight months of such hospital training had an average rank of 3.6—again higher than that of any comparable group.

Aside from these two factors, very little in the doctor's educational background seems to make much difference. You might think that clinical skill would be influenced by father's occupation; type of medical school attended; length and quality of hospital training in surgery, pediatrics, or obstetrics and gynecology. But apparently none of these has a measurable effect.

P.G. Work vs. Skill

Some more time-honored medical beliefs are shattered when we compare the North Carolina G.P.s' post-graduate study habits with their clinical rankings. The researchers' first finding:

There's no consistent relationship between the quantity of refresher work a man does and the quality of his clinical performance.

The G.P.s studied took anywhere from 110 hours of refresher training annually to none at all. Such training included hospital and medical society clinical sessions as well as formal courses.

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The top-rated clinicians in Rank V averaged forty-seven hours a year-a higher average than in any other rank. But when all surveyed doctors are classified according to the number of hours of refresher work they put in annually, we find that the men who take a moderate amount of such work (forty to fifty-nine hours) have a better average rank as clinicians than those who take sixty hours or more. (In the table that follows, Roman-numeral rankings have been converted to Arabic numerals—the higher, the better.)

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Hours of Refresher Work Annually	Average Clinical Rank
60 and over	2.61
40-59	3.21
20-39	2.58
0-19	2.43

The researchers conclude that "doctors who do more than sixty hours ... annually may be doing more than is necessary for their purposes, or ... interest in medicine or study may not be their primary motivation in attending medical meetings."

Courses Too Complex

They're inclined to think, too, that many courses simply aren't fitted to the family doctor's needs. P.G. courses, they say, are

... curb his appetite with DESOXYN

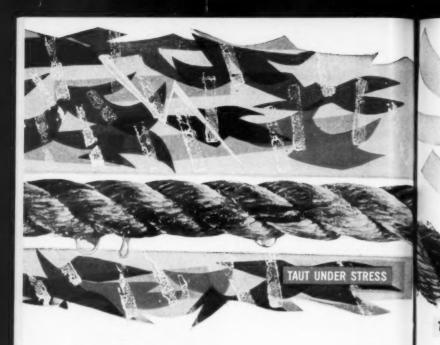
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MEDICAL ECONOMICS - JULY 1957 225



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Consistently effective control of visceral spasm and hypermotility of smooth muscle is assured by Donnatal through its three natural belladonna alkaloids, plus phenobarbital. Judiciously balanced for optimal synergism, they have been found superior to atropine alone in range of action-and more dependable and less toxic than the synthetic preparations.2 "Excellent results" in "a wide range" of gastrointestinal disturbances.1

- 1. Marks, L.: In press.
- 2. Morrissey, J. H.: J. Urol. 57:635, 1947.

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each Tablet Capsule Elixir (5 cc.)

Hyoscyamine sulfate 0.1037 mg. 0.0194 mg. Atropine sulfate Hyoscine hydrobromide 0.0065 mg. 16.2 mg. (¼ gr.) 48.6 mg. (¾ gr.) Phenobarbital

(Extended action tablet) 0.3111 mg. 0.0582 mg. 0.0195 mg.

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HOW DO GOOD DOCTORS GET THAT WAY?

often too theoretical, too advanced, or too complex to be covered in the allotted time.

Is it a waste of time, then, to sign up for such courses? The researchers don't go so far as to say that.

Formal Courses Better

They found that doctors who attended only medical society and hospital meetings were considerably less skillful, on the average, than the men who took formal courses. But the doctors who took from one to nine hours of formal work actually ranked

slightly *higher* as clinicians than the men who took forty or more hours.

Without drawing any hardand-fast conclusions on this point, the researchers say: "Either good doctors tend to do formal post-graduate study or doctors are made better by doing it."

The grades a man got in medical school bear almost no relation to his later study habits, the research team found. Neither does the length, type, or quality of interneship and residency training.

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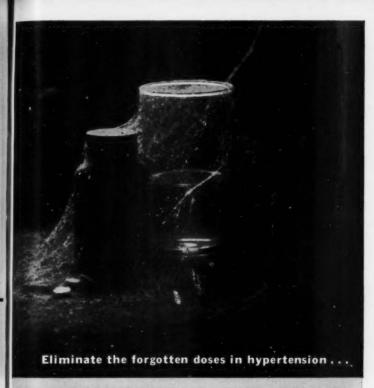


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*T.M. Reg. U.S. Pat. Off. Patent Applied For.

MEDICAL ECONOMICS · JULY 1957 229

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Aging Is Inevitable -Premature "Damage" Is Not

Steroid-Nutritional Therapy Helps Maintain Health and Vigor in the "Second Forty Years"

The patient who complains of "just getting old" need not be abandoned to a nonproductive life of discomfort. Positive therapy may arrest, or even reverse, the premature damage of gonadal decline and nutritional inadequacy in the growing population of older patients.

Complaints of such symptoms as muscular pain, fatigue, irritability, and poor appetite in the patient over 40 may be the first indications of three major stress factors in the aging process: gonadal hormonal imbalance, nutritional inadequacy, and emotional instability. Institution of adequate measures reduces immeasurably the likelihood of premature disability, chronic illness, and uselessness in later years.1

"Mediatric" is specifically formulated to guard against premature damage and breakdown of body reserves; to re-establish homeostasis in declining cells, thus delaying the degenerative process; and to raise the level of health by restoring physiologic efficiency.

"Mediatric" provides estrogen and androgen in small doses, nutritional supplements, and a mild antidepressant to promote continuing health and vigor.

Recommended dosages: Male tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required. Female tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required, taken in 21 day courses with a rest period of one apsules week between courses.

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d-Desoxyephedrine HC1...... 1.0 mg. Tablets-No. 752-bottles of 100 and 1,000. Capsules-No. 252-bottles of 30, 100, and 1,000.

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("Premarin"®) 0.25 mg. 2.5 mg. Methyltestosterone Thiamine HCl (B₁)..... Vitamin B₁₂ 1.5 mg. 0.33 mg. Folic acid U.S.P. d-Desoxyephedrine HC1..... 1.0 mg. contains 15% alcohol

No. 910-bottles of 16 fluidounces and I gallon.

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MEDIATRIC" helps restore physiologic efficiency when e patient exhibits signs of ... decreased muscular tone ... loss of dy mass

older patients, these symptoms are frequently the first signs of physiogic deterioration. Prompt institution of "Mediatric" therapy may restall and even reverse premature "damage" and help prolong the tive life of the patient.

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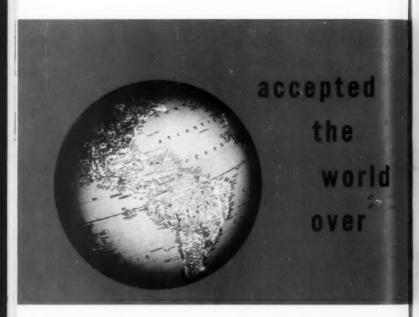
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GOOD DOCTORS

What about the effects of medical society affiliations? The researchers report that the North Carolina men had almost 400 society memberships among them, with an average of 4.2 per doctor. Finding:

There's no measurable relationship between the quality of a doctor's work and the number of medical societies he belongs to.

Similarly, the type of medical society seems to have little effect on the physician's competence—with one exception:

Members of the American Academy of General Practice tend to be better-than-average clinicians. The A.A.G.P. is the only national medical organization that requires its members to take regular refresher training. That training must average at least fifty hours a year—roughly the amount that the North Carolina researchers hit on as ideal.

But the study team isn't convinced that it's the A.A.G.P. refresher requirement that accounts for the clinical superiority of its members. The Academy has been in existence for just ten years—perhaps not long enough for the effects of such training to show up. The researchers suspect that members may be better because of "self-selection." That



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For patients who must stay on the job



Easy to Carry. Pleasant to Chew Fast Efficient Results

The formula of BiSoDoL Mints readily indicates why they afford such prompt and effective relief from heartburn and indigestion due to gastric acidity. No side effects. No constipation. No acid rebound or alkalosis. Free from sodium ion — BiSoDoL Mints help restore the normal pH of the stomach to maintain the optimum in physiological functioning. Most convenient for working patients to carry in their pocket or purse.

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GOOD DOCTORS

is, the G.P.s most interested in improving their work are the ones most interested in joining.

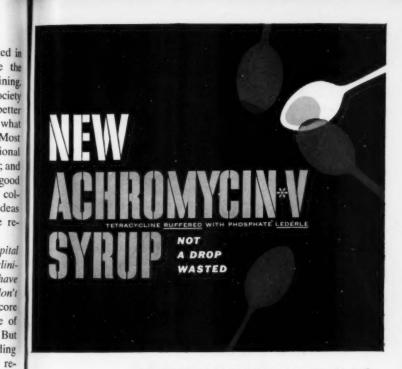
If the average medical society doesn't do much to make better doctors of its members, what about the average hospital? Most hospitals conduct educational programs for their staff men; and presumably it does a man good to be able to observe his colleagues at work and swap ideas with them. Yet here is the researchers' finding:

Doctors on an active hospital staff don't rank higher as clinicians than men who either have no hospital connections or don't use them. Staff doctors did score somewhat higher in the use of laboratory aids for diagnosis, But not on other counts, including over-all clinical skill. The researchers conclude:

"It seems . . . that the physicians and the citizens of a community determine the level of care which will be extended by their hospital . . . [It doesn't seem] that the hospital specifically influences the level of care rendered by the physicians comprising its staff."

Incidentally, though some of the North Carolina men didn't have hospital connections, this was entirely a matter of their own choice. Every doctor who wanted

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Youngsters really go for the taste-true orange flavor of ACHROMYCIN V SYRUP. But this new syrup offers more than "lip-service" to your junior patients. It provides the new benefits of RAPID-ACTING, phosphate-buffered ACHROMYCIN V-

- accelerated absorption in the gastrointestinal tract earlier, higher peaks of concentration in body tissue
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ACHROMYCIN V SYRUP: aqueous, ready-to-use, freely miscible. 125 mg. tetracycline per 5 cc. teaspoonful phosphate-buffered.

DOSAGE: 6-7 mg. per lb. of body weight per day.

*Reg. U.S. Pat. Off.

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MEDICAL ECONOMICS · JULY 1957 233

XUM

a hospital appointment had one. (It's true, though, that some of the men had been turned down by certain hospitals and that others were restricted in their obstetrical and surgical work.)

A final check-point in evaluating the G.P.s' refresher training was the number of medical journals they subscribed to. The average man took a fraction over four such publications. The researchers' finding:

The more medical journals a man takes, the better doctor he's likely to be. This shows up clearly in the following tabulation of the average number of journals subscribed to by men in each clinical rank:

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Naturally, none of the findings reported here necessarily reflects what any individual physician is like. Some of the best doctors surveyed took almost no post-graduate work and read very few journals; some of the poorest clinicians put in a lot of time on such things.

Next month, I'll take up the apparent connection between a doctor's office set-up and his clinical skill.

How Post-Graduate Study Habits Relate to Clinical Skill

The North Carolina study suggests that a G.P. is likely to be an above-average doctor if he:

- Does forty to fifty-nine hours (no more, no less) of refresher work annually
- 2. Belongs to the American Academy of General Practice
- Subscribes to more than four medical journals

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for skeletal muscle spasm

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In addition to its spasmolytic effect, Disipal evokes a mildly euphoric response, particularly valuable in the Parkinsonian patient.

Disipal is nonsoporific. Continuous therapy for as long as 44 months produced no serious ill effect, no tolerance.

In 480 cases of Parkinsonism (arteriosclerotic, postencephalitic, and idiopathic), 50 investigators reported good to excellent results in 286 (59%), and fair in 97 (20.2%).

In 120 cases of other types of muscle spasm, good results were obtained in 59 (49.1%) and fair results in 24 (20.1%). Side effects are minimal.

Dosage: Initially 1 tablet (50 mg.) t.i.d. In combination with other spasmolytic drugs, dosage is titrated to meet individual needs.

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U.S. Patent No. 2,567,351. Other patents pending.



Liability Claims Hit One M.D. in Seven

A nation-wide survey discloses that malpractice suits are 'the problem of the many, not the few'

By R. W. Tucker

Your chances of having a malpractice claim filed against you are about one in seven, according to the A.M.A. Law Department. This startling statistic comes from a first-of-its-kind study of professional liability that the department has been working on for two years.

In a report delivered last month to the A.M.A. House of Delegates—and endorsed by that body—the Law Department explains that it sent questionnaires "to approximately 7,500 members of the American Medical Association, representing a random sample of about 5 per cent of the membership. Of these questionnaires . . .

severe asthma

is usually aggravated and prolonged by a strong emotional overlay

In one study, 'Thorazine' relaxed and improved 11 of 12 patients within one hour after injection . . . in one case "appeared to be life-saving." 1

'Thorazine' promptly alleviates the emotional stress which may precipitate, aggravate or prolong an asthmatic attack. It enables the patient to sleep, yet does not depress respiration.

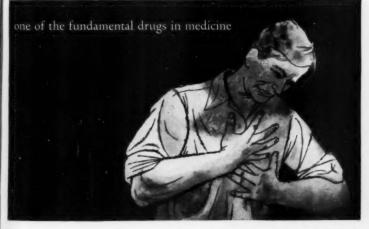
Available: Ampuls, Tablets, Syrup (as the hydrochloride), and Suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

1. Ende, M.: Am. Pract. & Dig. Treat. 6:710 (May) 1955.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

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MEDICAL ECONOMICS · JULY 1957 23'



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LIABILITY CLAIMS

5,341 were . . . returned." Over 14 per cent—about one-seventh -of the responding doctors revealed that they'd incurred malpractice claims sometime during their professional careers.

The study's chief conclusion -supported by the one-out-ofseven statistic-is that "professional liability claims are not limited to a small group of 'malpractice prone' doctors. Among the physicians who indicated that they had experienced claims, 86 per cent incurred only one claim in their entire professional practice. Only 10 per cent . . . had two claims . . . Our figures indicate that professional liability is the problem of the many, not the few."

Which doctors are most likely to incur claims? First and most important, says the Law Department, those who occasionally clash with their patients: "An element which is present in all professional liability claims is dissatisfaction arising out of physician-patient relations. Many of the cases which . . . involved substandard medical treatment would probably not have matured into claims had it not been for some other cause of friction ..."

Field of practice is an important factor too. Says the study: "31 per cent of the [reported]

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MEDICAL ECONOMICS · JULY 1957 239

claims involved surgery; 20 per cent medicine; 20 per cent orthopedics; 12 per cent obstetrics and gynecology; 6 per cent neuropsychiatry; 6 per cent anesthesiology..." But whether you're a G.P. or a specialist apparently makes little difference, the Law Department adds.

Hospitals are far and away the major malpractice trouble spot. "More than two out of three of the incidents resulting in professional liability claims occur in hospitals," the Law Department finds. It has recommended that the A.M.A. Trustees open "discussions with representatives of the American Hospital Association with the objective of formulating and implementing an effective in-hospital... prevention program." The department adds:

"The objective of the medical profession is not the prevention of professional liability claims as such, but the prevention of avoidable errors and omissions that result in injury to the patient and stimulate litigation . . ."

This proposal, if it's carried through, may be the most important consequence of the department's study. One reason: Only "72 per cent of the physician-respondents who had claims [brought against them] reported that they had personally performed the treatment or act of alleged malpractice." In other words, 28 per cent of all claims resulted from non-M.D. activities done at the doctor's risk. Which logically leads the Law Department to this conclusion:

"An effective educational and accident-prevention program should include not only physicians, but physicians' employes and the hospital personnel for whose acts the physician may be responsible."

Is the malpractice situation getting worse? In some states it appears to be, the A.M.A. study shows: "For example, 60 per cent of the California physicians [polled] said that in their opinion there has been an increase" in claims during the past five years. And in Louisiana, New York, Rhode Island, Utah, the District of Columbia, and Hawaii, "there was a [similarly] clear-cut expression of opinion that professional liability claims have increased in frequency."

Opinion from other states was less conclusive. But across the country, the Law Department notes, "54 per cent of those who have had claims said that the Pinl

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"...Of 90 patients with low back pain and other muscular conditions...
67 (74 per cent) showed a good response..."

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(1) Johnson, H, J., Jr.: To be published. (2) Wallace, S. L.: To be published.

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*U.S. Patent Pending

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"...a calmative effect...superior to anything we had previously seen with the new drugs,"*

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dosage: 150-300 mg. (½ to 1 tablet) three or four times daily. supplied: 300 mg. scored tablets, bottles of 48 and 500.

*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy 3:329, 1956.

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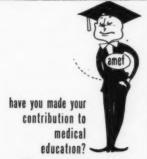
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LIABILITY CLAIMS

claims were brought against them since 1950."

What's the ultimate solution? The Law Department believes that "most professional liability claims can be prevented if knowledge of the causes of past claims is put to intelligent use." But it adds this sobering thought:

"Professional liability cannot ... be regarded as a legal problem exclusively. It is also a *medical* problem, and one which in our opinion requires the same intensive study that the profession has devoted to the conquering of disease ..."



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Your New Ethics Code

It's the shortest and simplest in U.S. medical history, but the A.M.A. says it covers all essentials

By Hugh C. Sherwood

Twenty-four hours before the A.M.A.'s annual session got under way last month, one well-informed medical man laid odds of 4 to 1 that the House of Delegates would refuse to pass the proposed new Principles of Medical Ethics. Too many delegates, he reported, thought the text didn't cover enough essential matters.

Twenty-four hours later, he said the odds had dropped to even money. And that's where they seemed to stay during the next four days. Speakers at the reference committee hearing were about evenly divided in their views on it. "You can't tell what the House will do," asserted a former A.M.A. president just before the final debate.

But the final floor debate was short and to the point—just like the new code itself. A motion to send it back to the committee for further study was decisively beaten. The House then approved the proposed text after changing just one word in it. ("The welfare of the individual" became "the well-being of the individual," Dr. Milford

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MEDICAL ECONOMICS · JULY 1957

YOUR NEW ETHICS CODE

O. Rouse of Texas having persuaded the delegates that the word "welfare" had unfortunate political connotations.)

As a result, the nation's doctors have a new statement of medical ethics. The code is reproduced in full on pages 256, 259, and 260.

Why was the original opposition to it so widespread? And why did the opposition collapse so completely? This article conveys the answers as they emerged from the A.M.A.'s latest session and from the new principles themselves.

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They're the shortest in the history of American medicine. They're limited to a preamble and ten sections totaling only 522 words. By contrast, the old principles comprised a preamble and forty-seven sections totaling roughly 4,000 words.

Besides being briefer, the new code differs from the old one in

two other ways:

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1. It doesn't deal with matters of medical etiquette. Absent from the new code are statements like this from the old one: "All physicians concerned in consultations should be punctual."

It doesn't attempt to lay down specific rules covering all ethical problems. Instead, it limits itself to broad statements

of general principles.

This latter limitation was the main reason that opposition arose. The code's critics argued that certain principles and prohibitions had to be spelled out in more precise detail. Otherwise, they felt, doctors couldn't be sure what their rights were in such matters as dispensing drugs; and other people couldn't be sure what doctors' rights were in such matters as corporate practice.

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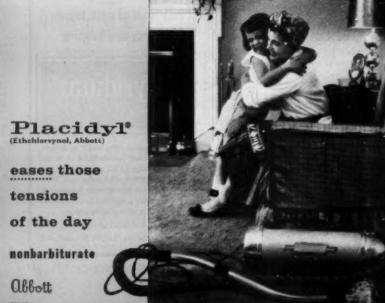
YOUR NEW ETHICS CODE

regents of the American College of Surgeons, voiced the sentiments of a majority of the code's critics when he said: "Many loopholes are left . . . The whole matter must be discussed in more detail."

A Mississippi doctor said: "To adopt this code would be like supporting the slogan 'Love thy neighbor.' The words can be interpreted in many different ways."

And Dr. Kenneth C. Sawyer, a Colorado delegate, spoke in favor of a resolution introduced by his state society that recommended outright disapproval of the proposed code. Colorado doctors were disturbed in particular by the lack of a specific statement upholding free choice of physician.

Then the supporters of the new principles (including the doctors who had spent nearly five years working them up) began to make their weight felt. It would be impossible to write specific rules covering every ethical problem in every section of the country, they pointed out. Dr. Dexter H. Witte, an A.M.A. delegate from Wisconsin, made



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MEDICAL ECONOMICS · JULY 1957 249

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YOUR NEW ETHICS CODE

this clear with a rhetorical question: "How can we spell out laws [to cover the many different medical problems in] both New York City and Slinger, Wis.?"

Dr. Louis A. Buie, past chairman of the A.M.A. Council on Constitution and Bylaws, asked another: "Could a statement of principles of [even] 800,000 words cover every situation?" Of course not, he implied.

The supporters of the new code also argued that it could and probably would be supplemented by other codes drawn up by state medical societies.* This point was made effectively by Dr. C. Paul White of Illinois, who added: "There never will be a settlement of the A.M.A. code if we try to spell things out as definitely as some have proposed."

The clincher came from Dr. Buie. He pointed out that the A.M.A. Judicial Council was also prepared to back up the code's general statements with specific rulings of its own. Earli-

⁶The A.M.A. House of Delegates specifically authorized this in an action reported on page 168, this issue.

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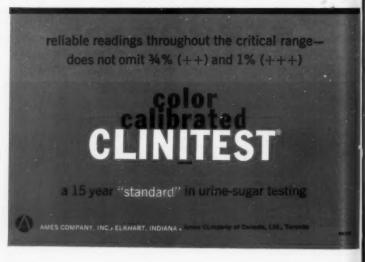
Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

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Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,² and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. 23:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. 163:260 (Jan. 26) 1957.



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er in the convention, Dr. B. E. Pickett Sr., present chairman of the Council on Constitution and Bylaws, had told the House:

"The fear has been expressed by others that by adopting this short but comprehensive statement of ethical principles, the profession will somehow lose the benefit of the valuable explanatory reports and opinions published by the Judicial Council during the last fifty years. This fear is groundless. The Judicial Council has now completed an annotation of the principles, and it is possible to determine, almost at a glance, the prior interpretations of the Judicial Council with reference to any section of the principles. These annotations, furthermore, will be supplemented by further annotations...Nothing of the wisdom of the past, present, or future will be lost..."

Having heard these arguments, the delegates' reference committee concluded that a general guide was better than a specific one. Then it did a little touching up of the tentative text. This affected three controversial sections as follows:



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YOUR NEW ETHICS CODE

Section 6, in its tentative form, contained a clause that would have specifically barred a physician from disposing of his services in such a way as to "permit the exploitation of his services for financial profit." The committee cut out this clause, maintaining that "exploitation" was too difficult to define and that other clauses got across the general idea. (So did previous A.M.A. pronouncements still in effect, said the committee, referring to the 1951 "Guides for Conduct for Physicians in Relationships With Institutions.")

Section 7 tentatively approved drug dispensing by doctors "provided there is no exploitation of the patient." Once again, the word "exploitation" stopped the committee members. They'd heard a Massachusetts doctor ask: "What is 'exploitation'—a profit of 10, of 20, or of 50 per cent?" They'd heard no answer. So they rewrote the section to authorize dispensing "provided it is in the best interests of the patient."

Section 10 apparently made it mandatory for a physician to play a part in all health and wel-

In the anemia of pregnancy....

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*Holly, R. G.: Iron and Cobalt in Pregnancy, Obst. & Gynec. (Mar.) 1957.

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fare activities in his community. The reference committee rewrote this section so as to give the physician more choice in the community activities he supports.

In the end, the A.M.A. delegates went along with all this—except for that one word "welfare," which they decided to

leave to "the do-gooders," as Dr. Rouse called them. And the delegates applauded vigorously when Council Chairman Pickett offered a final prediction. These new principles, he said, "will stand as a lasting monument" to the progressive thinking of medicine.

A.M.A.'s New Principles of Medical Ethics

Preamble. These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should

strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. The

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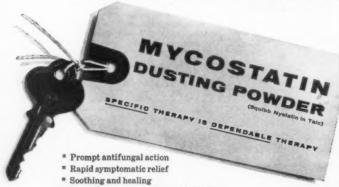
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should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill, or tend to cause a deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of pa-

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YOUR NEW ETHICS CODE

tients. Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8. A physician should seek consultation upon request; [he should also seek consultation] in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society, where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

END



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260 MEDICAL ECONOMICS - JULY 1957

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Chilling remarkably enhances the sherry Each fluid ounce (30 cc.) contains: flavor of GEVRABON. For some time physicians have been advantageously prescribing GEVRABON with ice as an appetite-stimulating tonic before mealtime -adding a refreshing touch to regular dietary supplementation for their senior patients.

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(as Ca glycerophosphate)	39 mg.
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at cerebral and peripheral levels

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spasmolysis without belladonna-like side effects

for duodenal ulcer • gastric ulcer • intestinal colic spastic and irritable colon • ileitis • esophageal spasm G. I. symptoms of anxiety states

prescribe: 1 tablet t.i.d. at

mealtime and 2 at bedtime

Formula:

Miltown® (meprobamate) 400 mg. (2-methyl-2-npropyl-1, 3-propanediol dicarbamate) U. S. Patent 2,724,720 tridihexethyl iodide 25 mg. (3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

2 Wolf & Wolf. Human Gastrie Function

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For anxiety, tension and muscle spasm in everyday practice.

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness

RELAXES BOTH MIND AND MUSCLE

WITHOUT IMPAIRING MENTAL OR PHYSICAL EFFICIENCY



Miltown

tranquilizer with muscle-relaxant action

2-methyl-2-ff-propyl-1,3-propanediol dicarbamate - U.S. Patent 2,724,720

Supplied: 400 mg. scored tablets 200 mg. sugar-coated tablets

Usual dosage: One or two 400 mg. tablets t.i.d.

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Relaxes
without
impairing
mental
or physical
efficiency

...well suited for prolonged therapy 1 "The primary finding of these studies is that meprobamate ['Miltown'] alone ... produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness and vision."

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 9, 1957.

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"Since it [meprobamate—'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used ... even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

"...the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical..."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] ... does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

"In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

> Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.

Miltown^{*}

2-methyl-2-n-propyl-1, 3-propanediol dicarbamate—U. S. Patent 2,724,720 TRANQUILIZER WITH MUSCLE-RELAXANT ACTION



SUPPLIED: 400 mg. scored tablets 200 mg. sugar-coated tablets USUAL DOSAGE: One or two 400 mg. tablets t.i.d. Literature and samples available on request



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Are You Talking Your **Colleagues Into Court?**

[CONTINUED FROM 122]

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nodded absently while writing on her chart. Then he caught himself and said emphatically:

"Shingles affects the nerves sometimes. That's what the city doctor wanted to ward off. It was worth a try. But since it didn't do the trick, we'll try something else."

3. You can routinely compliment good surgical results. A patient for whom a neighboring gynecologist had done a total hysterectomy recently visited her family doctor. "Ever since my operation," she said haltingly, "I get pains sometimes during sex relations."

The G.P. checked the pelvis and remarked: "There's nothing really wrong. Your organ's just sewed up too short." Then, realizing his blunder, he spent twenty minutes reassuring her. She wasn't completely reassured until she'd been checked by another gynecologist.

"Everything worked out all right;" the second gynecologist

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NEW! for patients of all ages

prevents and relieves skin discomforts... aids healing

- superior absorption keeps skin cool and dry
- anti-urease action inhibits ammonia formation
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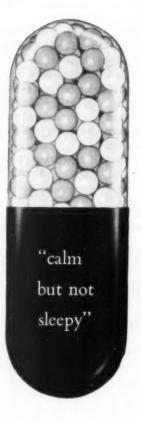
Ideal for your patients susceptible to: diaper rash, heat rash, urine scald, chafing, intertrigo, itching and burning feet and minor skin irritations.

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Compazine S



the outstanding tranquilizer an antiemetic in the uniqu

and convenient dosage for

available: 10 mg. and 15 mg 'Compazine' Spansule capsule "Make

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hysicians' Comments:

Causes less drowsiness than [another tranquilizer]."

IZET an Best results in nausea and vomiting of pregnancy I have ever seen."

I like the dosage form for the convenunique ience it affords the patient."

"Excellent for working people."

"Dynamic response. No nausea and vomge for iting after first dose."

atients' Comments:

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XUM

"I sleep like a baby and feel perfectly relaxed when I'm awake."

Never felt better in my life. Absolutely no headaches since taking 'Compazine'."

"The capsule really helped my nerves . . ."

capsult "Makes me feel wonderful. I'm less irritable around the house."

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T.M. Reg. U.S. Pat. Off. for proclorperazine, S.K.F. T.M. Reg. U.S. Pat. Off. for <u>sustained release</u> capsulos, S.K.F. tent Applied For



TALKING COLLEAGUES INTO COURT?

told me. "But the problem shouldn't have come up. Suppose the G.P. had examined her and said: 'That's a first-class job. Of course, this operation makes the vagina slightly shorter, so your husband may have to modify his technique a bit.'This would have set the patient at ease instead of stirring her up."

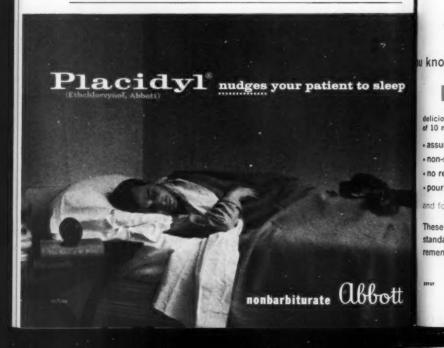
4. You can explain differences in therapeutic approach. Suppose a patient switches to your care because he's unhappy with his former doctor's results. Suppose you prescribe a new regime. One way to keep from implying

fault in the former doctor is to say something like this:

"The treatment you've had is the usual treatment. I probably would have tried it myself if I'd seen you then. Now that we know it isn't effective in your case, let's try something else."

5. You can point up new findings when you change the approach. Previous treatment may have been ineffective because the patient's problem was obscure at first. Some doctors deliberately make this clear. The actual phrasing? Something like this:

"These findings put your trou-



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they know what they like



wknow what they need for comprehensive vitamin protection

Deca-Mulcin

delicious orange-flavored teaspoon dosage of 10 nutritionally significant vitamins

- · assured stability, including B12
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small easy-to-swallow capsules of 10 nutritionally significant vitamins

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These three Deca Family Products have the same basic formulation and the same standard of comprehensive protection. The basic family name Deca is easy to remember and simplifies specification during the vital first decade.

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SYMBOL OF SERVICE IN MEDICINE

MEDICAL ECONOMICS · JULY 1957 267

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ble in a new light. Probably for the first time, it's possible to say definitely that you've got pneumonia. So here's what's called for..."

6. You can make it clear that doctors are only human. A leading stimulus to malpractice suits is the feeling that each physician ought to be able to get perfect results in every case. Here's how one surgeon gently disabuses patients of this notion:

"It's easy to miss a bit of tissue in a pilonidal case. I've done it myself."

"You mean my other doctor

didn't do the operation right?" the patient may ask. "Is that why this came back?"

"I mean that in trying to spare you a larger wound, he missed a tiny fragment. We've all done the same thing. We try to be perfect surgeons, but we're still human."

These are examples of patienthandling techniques that have worked well for other doctors. If they were more widely used, there'd be fewer unwarranted malpractice suits—and lower malpractice premiums foreveryone in the profession.

POWER FOR PEAK

THERAPEUTIC PERFORMANCE



Potentiated Mephenesin*

For relief of low back pain and other arthritic pain, for release of tension accompanying pain.

- Relieves pain
- Soothes tension
- Relaxes muscle spasm

Each EXPASMUS tablet contains: Dibenzyl succinate 125 mg., mephenesin 250 mg., salicylamide 100 mg. *Mephenesin physiologically potensified with a smooth muscle relaxant and analgesic . . . dibenzyl succinate Dosage: 2 to 3 tablets 3 times daily to

12 tablets daily. Supplied: Bottles of 100's tablets

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268 MEDICAL ECONOMICS · JULY 1957

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Now! OSTIC plaster bandages in RED, GREEN & BLUE

Give patients a little sunshine when they need it most...



Let's face it. A broken bone is no picnic. It can make even a brave youngster mighty scared. Anything that can help you relieve his anxiety by imparting a little fun is much to be desired.

And that's just what new, gaily-colored Ostic plaster bandages do. They're so cheerful, so light-hearted that they send tension down, patient co-operation up. (Works for adults, too!)

And remember this: Ostic in colors is the same high-quality, creamy, fast-setting plaster bandage as regular white Ostic. Only thing different is the colors—safe, non-toxic blue, green and red as well as white. Try Ostic in colors soon.

★ For even more fun . . . Give the kids

memberships in the Curity
HERO CLUB

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Every kid wants to be a hero...and youngsters with broken bones really

are. Now you can give 'em all a Hero's badge and a certificate of membership in the Curity Hero

Club. Badges and certificates packed inside every box of Ostic in colors.

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PLASTER BANDAGES
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Other top-quality orthopedic products from Curity

CURITY GYPSONA[®]... the famous plaster bandage made of imported plaster of Paris.

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MEDICAL ECONOMICS - JULY 1957 269

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Fastest-Growing Health Insurance Today

[CONTINUED FROM 131]

provides full payment of small expenses."

Labor leaders often say the same thing. Many of them oppose the insurance because it abandons the idea of fully prepaid medical care. Thus, they add, it works against the type of care that people need more of—preventive medical care. Says Jerome Pollack, a consultant to the United Auto Workers Union:

"The deductible is the most controversial feature of this insurance... Its function is to reduce the number of claims... [But] the medical importance of small claims [cannot] be dismissed... The initial decision whether to see a doctor or neglect a condition [often depends on whether insurance covers] the small claim."

'Too Few Benefit'

Another thing wrong with the deductible, as labor leaders see it, is that it shuts out too many workers from receiving any in-

Effective physiologic relief of
muscle and joint pain...

overcomes ischemia
stimulates cellular
metabolism
flushes out
pain-producing metabolites



86TH YEAR surance benefits. "More than two-thirds of the population incur total health service costs of less than \$50 annually," Pollack points out. If the deductible is set at that level, "only a small minority of insured people" get anything in return for their premium dollars.

Is It Inflationary?

Pollack also gives voice to the other big criticism of semi-comprehensive: that it may have an inflationary effect on medical costs—especially on fees.

"Normally," he says, "insurers

will not challenge a claim unless the fee is two, two and a half, or sometimes even three times that in a fee schedule used as a guide ... The abandonment of negotiated fee schedules without the development of a suitable alternative... [will] leave the patient to cope as an individual with a problem that medical societies and prepayment plans have often failed to solve."

Labor men aren't the only ones who fear that semi-comprehensive insurance will increase the cost of medical care. Some doctors fear so too. [MORE ▶

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VASODILATOR AND SAFE METABOLIC STIMULANT

In each VASTRAN tablet:

Asco	tinic acid	hydrochloride Calcium pantothenate Cobalamin (Vitamin 8-2 activity DO and 500.	e5 mg. 2 mcg.
Nice	tinic acid (as sodium salt) nosine-5-Monophosphoric acid nin B ₁₂	d (as sodium salt)	20 mg. 25 mg.

Also effective in revitalizing geriatric patients, and in relieving circulatory insufficiency, as in Raynaud's disease, Buerger's disease, varicose veins and other peripheral vascular disorders.

After each dose—oral or intramuscular—patients experience a warm, tingling flush to substantiate Vastran's vasodilating effect. Extensive clinical evidence shows that nicotinic acid, as provided in Vastran, can effectively ease muscle and joint pains **physiologically**—by increasing peripheral circulation and oxygenating tissues. Other coenzymes in Vastran stimulate metabolism and help transform food into dynamic energy. **Result**: Vastran provides relief of muscle and joint pain, improved joint mobility and greater vitality, without depressive medication.

Send for free sample of VASTRAN tablets and literature

WAMPOLE LABORATORIES
Henry K. Wampole & Co., Inc. · Philadelphia 23, Pa.

One of them is Dr. William H. Horton, executive director of Connecticut's Blue Shield. He doesn't object to deductibles and co-insurance as such. But, he says, by setting the first as low as \$25 and the second as low as 20 per cent or less, semi-comprehensive plans are seriously limiting their control over medical costs. "The abandonment of controlling factors and the payment of 'going rates' puts medical care in the constantly upward inflationary spiral," he believes.

What do the insurance companies have to say about this? MEDICAL ECONOMICS recently queried nearly forty that offer semi-comprehensive and/or major medical coverage. Almost all indicate some anxiety lest doctors upgrade their fees because of the high maximum benefits and the lack of fee schedules. A good many say they've already run into such upgrading.

'Doctors Overcharge'

One company refused to answer the questionnaire, saying: "We are not interested in educating the doctors [about this type of insurance]. They have the ability to quickly diagnose ways and means of increasing their

fees as insurance coverage is broadened . . . in many instances [our policyholders] have openly stated that the doctor has overcharged and should not be paid. Those statements . . . bear out our experience that the doctors are . . . trying to take advantage of the increased benefits . . ."

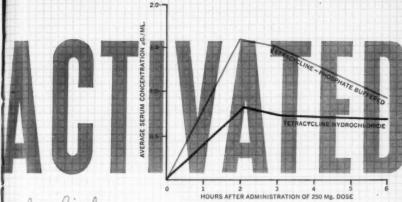
'We Have No Problems'

Much more typical is this report from Frank L. Harrington, President of the Paul Revere Life Insurance Company: "We have no problems with 99 per cent of the doctors. [Only] a few appear to substantially increase their charges in view of the insurance."

Says Joseph W. Moran of New York Life: "[My] company is banking heavily on the continuing cooperation of the medical profession in setting professional charges independently of the insurance benefits available. Of course, the use of the co-insurance approach, rather than the schedule approach, represents a strong bid for this cooperation, since it will completely eliminate any implication that the insurer is trying to dictate the fees that the doctors...charge." [MORE]

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y. Pfizer





for higher, Laster blood levels of tetracycline

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Tetracyn V, tetracycline-phosphate buffered, given orally, produces "markedly higher serum concentrations than those obtained with tetracyclin hydrochloride.*1

In a crossover study, Tetracyn V afforded serum levels higher than tetracycline hydrochloride at two, three and six hours, following oral administration.

Therapy with activated Tetracyn V thus provides a higher, faster activity level of tetracycline, established as outstanding in effectiveness and safety among broad-spectrum antibiotics.

SUPPLIED: Capsules, each containing tetracycline equivalent to 250 mg. tetracycline HCl, with added sodium metaphosphate.

 Welch, H.; Lewis, C. N.; Staffa, A. W., and Wright, W. W.; Antibiotic Med. & Clin. Therapy 4:215 (April) 1957.

TETRACYN'N

tetracycline-phosphate buffered

FASTEST-GROWING HEALTH INSURANCE

All of which indicates why medical leaders are urging restraint on their colleagues. Says Dr. Harvey Renger, chairman of the Texas Medical Association's Council on Medical Economics: "I honestly believe that had it not been for the insurance industry . . . we would have had the socialization of our profession . . . It behooves us to do our utmost to cooperate with the insurance field . . . We must be fair, and fill out our reports promptly and accurately, and ... charge reasonable ... fees."

All doubts and dissents not-

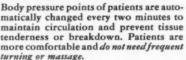
withstanding, semi-comprehensive shapes up as an important new development in health insurance—important to doctors, vitally important to the Blue Shield plans they sponsor. Its impact on the Blue plans will be reported in a later article. Meanwhile, you can get some inkling of what that impact is from a prediction made by a spokesman for the Nationwide Mutual Insurance Company. About semi-comprehensive, he says this:

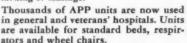
"It may well be *the* health insurance protection of tomorrow."

Alternating Pressure Point Pads Prevent and Help Heal PRESSURE SORES



Your threatened and existing cases of pressure sores need not be a problem. APP units will prevent and help heal them.





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THE R. D. GRANT COMPANY

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Cleveland 14, Ohio

Manufactured by AIR MASS, INC., Cleveland 10, Ohio



This open decubitis ulcer healed on an APP pad





"Frank! We really missed you!"

You recall Frank... just a while ago suspicious and resentful of his associates... convinced they were all against him. Gradually he became trigger-sensitive to criticism, incensed over his wife's supposed infidelity, full of hypochondriacal complaints and fears. Because of this alarming personality change, Pacatal was instituted: 25 mg. t.i.d. Pacatal therapy saved this executive from an imminent breakdown.

For patients on the brink
of serious psychoses, Pacatal
provides more than tranquilization.
Pacatal has a "normalizing" action;
i.e., patients think and respond emotionally
in a more normal manner. To the self-absorbed
patient, Pacatal restores the warmth of human
fellowship... brings order and clarity to muddled
thoughts... helps querulous older people
return to the circle of family and friends.

Pacatal, in contrast to many phenothiazine compounds and other tranquilizers, does not "flatten" the patient. Rather, he remains alert and more responsive to your counselling. But, like all phenothiazines, Pacatal should not be used for the minor worries of everyday life.

Pacatal has shown fewer side effects than the earlier drugs; its major benefits far outweigh occasional transitory reactions. Complete dosage instructions (available on request) should be consulted.

Supplied: 25 and 50 mg. tablets in bottles of 100 and 500. Also available in 2 cc. ampuls (25 mg./cc.) for parenteral use.

back from the brink with

Pacatal Pacatal

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100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

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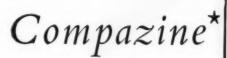
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the outstanding tranquilizer and antiemetic in the unique and convenient dosage form

available: 10 mg. and 15 mg. 'Compazine' Spansule capsules

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Physicians' Comments:

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"Causes less drowsiness than [another tranquilizer]."

"Best results in nausea and vomiting of pregnancy I have ever seen."

"I like the dosage form for the convenience it affords the patient."

"Excellent for working people."

"Dynamic response. No nausea and vomiting after first dose."

Patients' Comments:

"I sleep like a baby and feel perfectly relaxed when I'm awake."

"Never felt better in my life. A bsolutely no headaches since taking 'Compazine'."

"The capsule really helped my nerves . . ."

"Makes me feel wonderful. I'm less irritable around the house."

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News

[MORE NEWS ON PAGE 14]

Hospital Lab Standards Called 'a Shambles'

"Penny-pinching by hospital administrators, combined with an acute shortage of medical technologists, is making a shambles of hospital laboratory standards—if not actually imperiling hospital patients."

That's the considered judgment of many leading pathologists and medical technologists, according to a recent survey by The Modern Hospital. Here's how the magazine analyzes what seems to be causing the trouble:

Penny-pinching: "Too many hospital administrators and pathologists hire inadequately or poorly trained technicians under the impression that the few dollars saved on salaries are a real economy for the hospital. [Often] salary scales are illogical, with well-trained, registered technologists doing the same work, for the same pay, as graduates of substandard schools and laboratory assistants with only

on-the-job training. This practice adds [up] to low job satisfaction and high turnover."

Personnel shortage: "Authorities estimate that 50,000 qualified technicians are needed for laboratories today . . . Approved schools are graduating fewer than 5,000 a year. [And] while there are many splendid schools among the 646 approved for training medical technologists, too many . . . are behind the times when it comes to teaching."

The basic cause of the deterioration, the magazine finds, is the "sudden, mushrooming growth of medical technology since the end of World War II."

Neither training nor salaries have kept pace with this growth, it reports.

"Medical educators . . . are seriously re-examining the courses offered medical students," The Modern Hospital points out. "Courses in the paramedical professions deserve similar attention." As to pay scales, it declares, "the compeNow...control both the G.I. disorder and its "emotional overlay"

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[MORE NEWS ON PAGE 14]

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Hospital Lab Standards

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combines Meprobamate (400 mg.):

Widely prescribed tranquilizer-muscle relaxant. Effectiveness in anxiety and tension states clinically demonstrated in millions of patients. Meprobamate acts only on the central nervous system. Does not increase gastric acid secretion. It has no known contraindications, can be used over long periods of time. 1-2-3

with Pathilon (25 mg.):

An anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of G.I. tract disorders. In a comparative evaluation of currently employed anticholinergic drugs,

PATHILON ranked high in clinical results, with few side effects, minimal complications, and few recurrences.

Now...with PATHIBAMATE...you can control disorders of the digestive tract and the "emotional overlay" so often associated with their origin and perpetuation...without fear of barbiturate loginess, hangover or addiction. Among the conditions which have shown dramatic response to PATHIBAMATE therapy:

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SPASTIC AND IRRITABLE COLON • ILEITIS • ESOPHAGEAL SPASM

ANXIETY NEUROSIS WITH G.I. SYMPTOMS • GASTRIC HYPERMOTILITY

Referentia press, Clin. 169 In press, Therapy (July) 19: Lederic I Communicated McC

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Comments on PATHIBAMATE from clinical investigators

- "I find it easy to keep patients using the drug continuously and faithfully. I feel sure this is due to the desirable effect of the tranquilizing drug."
- "The results in several people who were previously on belladonna-phenobarbital preparations are particularly interesting. Several people volunteered that they felt a great deal better on the present medication and noted less of the loginess associated with barbiturate administration."
- PATHIBAMATE..."will favorably influence a majority of subjects suffering from various forms of gastrointestinal neurosis in which spasmodic manifestations and nervous tension are major clinical symptoms."
- "In the patients with functional disturbances of the colon with a high emotional overlay, this has been to date a most effective drug,"

References: 1. Borrus, J. C.: M. Clin. North America, In press, 1937. 2. Gillette, H. E.: Internat. Rec. Med. & G. P. Clin. 169: 433, 1956. 3. Pennington, Y. M.: J. A.M. M., In press, 1937. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. Am. J. Dig. Dis. 13: 1301-309 (July) 1956. 5. McGlone, J. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

Supplied: Bottles of 100 and 1000

Administration and Dosage: 1 tablet three times a day at mealtimes and 2 tablets at bedtime. Full information on PATHIBAMATE available on request, or see your local Lederle representative.

Pathibamate # 100 Sig: 1 tab. t.i.d. at mealtime. 2 tabs. at besting.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Letters to a Doctor's Secretary



In this up-to-the-minute volume, MEDI-CAL ECONOMICS has assembled its complete, step-by-step course of instruction for the physician's aide. Sixteen chapters cover such topics as:

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Bound between handsome, black laminated covers, with the title stamped in gold, this convenient pocket-size book contains 75 information-packed pages. Prepaid price: \$2.

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Street		
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282 MEDICAL ECONOMICS · JU	LY 1957	

tence implied by certification must be reflected in higher salary schedules for the registered medical technologist."

Editor Bites A.M.A.— And Gets Bitten Back

A.M.A.-baiting is an old newspaper trick. Much of it goes unchallenged, says the Rocky Mountain Medical Journal, because "few doctors have the time, inclination, or ability" to wield the pen effectively in the profession's defense. Which makes it news when an A.M.A.-baiter gets bitten:

A few months ago, the editor of the Arapahoe (Colo.) Herald asked his readers in print: "Did your child get a polio shot at school in the past year or two?" If so, he told them, "the youngster is practically a Communist now in the eyes of the American Medical Association, that powerful lobbyist organization which has opposed public health measures for two generations.

"The A.M.A. has forced the Government out of the polio-immunization program, effective next July, because the association thinks it is 'socialized medicine.' If this is socialized medicine, the people want more of it . . ."

When Harvey T. Sethman, executive secretary of the Colorado State Medical Society, read this editorial, he saw red. He wrote a letter to the editor and mailed it "while he was still mad." In his n must schednedical

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FURADANTIN°

BRAND OF NITROFURANTOIN

Intravenous Solution for severe infections

often rapidly effective

in bacteremia, peritonitis, and other bacterial infections as of postoperative wounds, and abscesses, when the organism is susceptible to Furadantin

 in severe genitourinary tract infections when the patient is unable to take Furadantin per os







NORWICH, NEW YORK

OFFICE OF THE MEDICAL DIRECTOR

Dear Doctor:

For your postoperative or severely ill patients unable to take antibacterial medication by mouth, Eaton Laboratories announces the availability of FURADANTIN INTRAVENOUS SOLUTION.

Furadantin I.V. is proving highly effective in refractory bacterial infections such as bacteremia and peritonitis, and other bacterial infections as of postoperative wounds and abscesses, when the organism is susceptible to Furadantin. In addition, Furadantin I.V. provides an important alternate route of administration for treating genitourinary tract infections in patients unable to take medication by mouth.

The results of clinical studies indicate that Furadantin Intravenous Solution should be tried in certain bacterial infections, refractory to other medicaments, when caused by organisms sensitive to Furadantin. In 75 extra-urinary tract infections including bacteremia, peritonitis, pneumonia, osteomyelitis and abscesses, 34% were cured with Furadantin Intravenous Solution, and an additional 45% were significantly improved.

Side reactions similar to those with oral Furadantin have been encountered, but no serious side effects have been observed in either adults or children.

Furadantin Intravenous Solution not only fills a long-felt need in the treatment of refractory urinary tract infections, but offers new hope in selected, severe systemic infections; even in those which have failed to respond to all other drugs. We are confident that Furadantin I.V. will play an important role in the treatment of your hospitalized patients with severe infections.

Sincerely,

Paul F. MacLeod, M.D.

Medical Director



FURADANTIN I.V.

FURADANTIN I.V. in severe urinary tract infections

No. Cases Cured Improved Failed 71 37(52%) 28(39%) 6(8%)

26(34%) 34(45%) 15(20%)

FURADANTIN I.V. in extra-urinary tract infections

No.	Cases	Cured	Improved	Failed
Peritonitis	6	8(50%)	2(33%)	1(16%)
Bacteremia	23	12(52%)	6(26%)	5(22%)
Postoperative Wound Infection	18	4(22%)	11 (61%)	3(16%)
Others (pneumonia, meningitis, osteomyelitis, otitis media, etc.)	28	7(25%)	15(53%)	6 (21%)

Total 75

In the following representative cases of urinary tract and extra-urinary tract infections—cases ranging from "severe" to "hopeless"—intravenous administration of Furadantin achieved clinical and bacteriologic cure or marked improvement in a high percentage. Often, a wide variety of antibiotics and sulfonamides had failed to control the infection.

Case Summaries

Sex; Age; Disease Treated	Causative Bacterium	Coexisting Disorder
M; chronic cystitis, pyelonephritis	Ps. aeruginosa in urine	
F; chronic pyuria with fever	E. coli in urine	
F; 39; pyelonephritis	Ps. aeruginosa in urine	Staghorn cal- culus, right
M; 79; bacteremia	E. coli in urine	Post-trans- urethral resection
F; pyuria, probable bacteremia	A. aerogenes in urine. Blood culture-neg.	Post-pan- hysterectomy
M; pyelitis, probable bacteremia, chills	E. coli, Ps. aeruginosa in urine	Bilateral renal calculi
Bacteremia	Blood culture positive	Psychosis

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ection. FURADANTIN I.V.

Furadantin I.V. Dosage	Result of Treatment	Remarks
180 mg. daily, 3 days	Cured	Resistant to broad spectrum anti- biotics and sulfonamides. In 3 days, afebrile; urinary frequency, urgency gone, urine culture negative.
180 mg. daily, 4 days	Cured	Resistant to penicillin and sulfona- mides. In 4 days, "afebrile and infection cleared," urine culture negative.
60 mg. q. 8 h., 3 days	Cured	Organism resistant in vitro to Furadantin. Changed to oral form after 3 days on I.V.
360 mg. q. 8 h. for 3 doses, then 180 mg. b.i.d. 2 days	Cured '	36 hours post-op, temp. 106.4°. Remission of fever 16 hours after starting Furadantin I.V. Negative urine culture in 5 days.
180 mg. b.i.d. for 3½ days	Cured	Antibiotics for 2 weeks. Added oral Furadantin 4 days. Patient semicomatose when Furadantin I.V. started. Afebrile in 24 hours. Urine culture sterile at 14th day.
180 mg. q.i.d., 5 days	Cured	When Furadantin I.V. started temp. 104°. In 24 hours, temp. 99°. Previous treatment included penicillin, streptomycin and sulfonamide for 5 days each. Patient discharged on oral Furadantin for 5 days. Returned to clinic with negative urine.
180 mg. daily, 2 days	Inconclu- sive, blood culture negative	"Patient had been resistant to penicillin and streptomycin." Chlortetracycline given inter- currently with Furadantin I.V.

Sex; Age; Disease Treated	Causative Bacterium	Coexisting Disorder
M; empyema and post-surgical wound infection	Pseudomonas sp.	Pulmonary TB, pneumo- nectomy
M; 75; acute pyelonephritis	None isolated from blood or urine but gross pus in urine	Prostatectomy month before
F; 77; cystitis, atypical pneumonia	(Not stated)	Diabetes mellitus
F; furunculosis	M. pyogenes var. aureus	Post-pyelo- nephritis
M; 62; recurrent gross hematuria, pyuria	Proteus sp. in urine	Benign hyper- trophic prostate
F; 69; peritonitis, bacteremia	E. coli in peritoneal fluid. Proteus sp. in blood	Cancer of colon with perforation, resection
M; 28; peritonitis, bacteremia	Proteus sp. in peritoneal fluid and blood	Ulcerative colitis, obstruction at ileostomy and perforation of small intestine. Resection of perforation and revised ileostomy. Shock
M; 76; pyelonephritis, cystitis	Proteus sp., A. aerogenes in urine	Bilateral renal calculi, uremia
3 weeks old infant; meningitis	E. coli in spinal fluid and urine	E

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Furadantin I.V. Dosage	Result of Treatment	Remarks
180 mg. daily, 3 days	Improved	Previous streptomycin and INAH, pneumonectomy. Empyema and wound infection with Pseudomonas. After Furadantin I.V. temp. normal, wound improved. Continued on oral Furadantin.
180 mg. b.i.d., 2 days	Cured	Temp. 103° reduced to normal, urine clear and patient discharged in 2 days. " without Furadantin I.V probably would have died."
180 mg. daily, 3 days	Cured	Penicillin-dihydrostreptomycin 5 days previous. Temp. 104.4° to normal 24 hours after Furadantin I.V. instituted.
180 mg. daily, 3 days	Markedly improved	Continued elevation in temp. (100-101° for 10 weeks in spite of intensive antibiotic therapy. Temp. dropped slowly to normal on Furadantin I.V. and no new furuncles developed.
180 mg. daily, 3 days	Improved	Previous sulfonamide treatment 7 days. Bacterium resistant to all tested drugs, slightly sensitive to Furadantin. Temp. normal in 3 days. Followed with oral Furadantin 6 days. TUR following day. Uneventful post-op.
600 mg. daily, 4 days	Cured '	Sensitive to chloramphenicol and Furadantin. Furadantin blood level 6-12.5 gamma/cc. Temp. subsided in 24 hours. Culture sterile in 4 days and no drainage. Patient discharged in 2 weeks.
600 mg. daily, 5 days	Cured	Sensitive to chloramphenicol and Furadantin. Furadantin blood level 12.6 to 14.2 gamma/cc.
240 mg. daily, 4 days	Cured	Oral Furadantin ineffective. With Furadantin I.V., cultures became sterile. Furadantin blood levels 2.9 to 6.2 gamma/cc.
3.3 mg./Kg. q. 12 h. for 5 doses	Cured	Fever 2 days. Received antibiotics and sulfonamides. Temp. 103° became normal in 16 hours following institution of Furadantin I.V. and remained so for duration of hospitalization.

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FURADANTIN Intravenous Solution

DOSAGE AND ADMINISTRATION: Furadantin Intravenous Solution contains 0.6% Furadantin, dissolved in polyethylene glycol 300. Each 10 cc. ampule contains 60 mg. of Furadantin. The solution is sterile and must be dissolved aseptically in a sterile diluent prior to use.

The recommended diluent is 5% dextrose solution. Furadantin Intravenous Solution is compatible with normal saline and ½ M sodium lactate solutions, but these should be used only when definitely indicated because of the possibility of further disturbing an already upset electrolytic balance. Administer as an intravenous drip at a rate indicated for the patient's general condition and age. The suggested dosage is 5 to 7 mg. per Kg. body weight (2.2 to 3.1 mg./lb.) per 24 hours in 2 divided doses. The single dose of Furadantin Intravenous Solution for the average adult is 30 cc. (3 ampules or 180 mg.) in at least 500 cc. of diluent. If tolerated, this is repeated so that 2 such doses (360 mg.) are given over 24 hours and continued for 7 days, if necessary. Following are average dosage schedules:

Weight of Patient	Size of Single Dose	Minimal Amount of Diluent
120 lbs. or over (54 Kg.)	30 cc. (3 amp.) = 180 mg.	500 cc.
80 to 120 lbs. (36-54 Kg.)	20 cc. (2 amp.) = 120 mg.	350 cc.
40 to 80 lbs. (18-36 Kg.)	10 cc. (1 amp.) = 60 mg.	175 cc.

In arinary tract infections, the intravenous form may be replaced by the oral dosage form of Furadantin when sufficient improvement has resulted and patient can take medication orally.

SIDE REACTIONS: Nausea or emesis may occur occasionally. These are often minimized by a decrease in dose rate. Sensitization occurs rarely in the form of unticaria or an erythematous, maculopapular rash. This may be controlled by discontinuing treatment immediately and employing the usual measures such as epinephrine, antihistaminics or adrenocorticosteroids. Occasionally patients may show minor side reactions such as headache or malaise. No stomatitis, colitis, proctitis, anal pruritus, monilial superinfection, staphylococcic enteritis or renal, hepatic or hemic toxicity have been reported.

With intravenous administration, it is important to be alert to the possibility of central nervous system effects such as muscular twitching or spasticity. Should this occur, calcium gluconate should be administered intravenously and Furadantin discontinued. Adequate amounts of vitamin B complex and vitamin C should be supplied to the patient on intravenous Furadantin therapy.

SUPPLIED: Sterile 10 cc. ampules (60 mg. Furadantin each), box of 12.

№OTE: Furadantin Sensi-Discs (100 mcg.) for sensitivity testing are available from the Baltimore Biological Laboratories. Materials and instructions for serial-tube dilution tests may be obtained from the Medical Director of Eaton Laboratories. To simplify sensitivity testing with Furadantin and to provide maximum reproducibility and reliability, Eaton Laboratories has prepared a new booklet, "Bacterial Sensitivity Testing with Furadantin and Furacin," copies of which may also be obtained by writing to the Medical Director.

For oral administration in the treatment of genitourinary tract infections: Furadantin tablets, 50 and 100 mg.; Furadantin Oral Suspension, 25 mg. per 5 cc. tsp. NITROFURANS-a new class of antimicrobials-neither antibiotics nor sulfonamides

PRODUCTS OF EATON RESEARCH-EATON LABORATORIES, NORWICH, N. Y.

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sharply worded rebuttal (which was printed a few days later) Sethman told the editor he should have read his own telegraphic newsservice bulletins:

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"If you had," said Sethman, "you would have known that the A.M.A. has been and still is spending thousands of dollars of its own money and giving thousands of hours of its members' time daily to do exactly the opposite of stopping polio shots. You would have known... [the A.M.A.'s] objective is the vaccination of every person in the United States under age 40 who is willing to accept the shots, with or without professional fees. You would have known... doc-

tors are donating their time, willingly, to organize free clinics for the indigent, cost-of-vaccine-only clinics for anyone else who will come, school clinics and industrial plant clinics and still others...

"You would also have known that the Colorado State Medical Society, in an action shattering all precedents against its limiting a doctor's own judgment as to what his own professional time is worth, ten days ago fixed a maximum limit of \$3, including vaccine and all other costs, which a Colorado doctor should charge a private patient for polio vaccination in the doctor's private office.

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STEROSAN-Hydrocortisone

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for constipation

Whenever constipation complicates therapy, prescribe Agoral . . . for gentle effective laxation.

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NEWS

their shots for \$1.25 or \$1.50, according to location. This will cover only the cost of vaccine (usually about 80 cents) plus the out-of-pocket cost for technicians and equipment rental at the clinics."

After reporting this exchange, the Rocky Mountain Medical Journal said with satisfaction: "The newspaper's editor is appro-

priately chastised."

Medicare Pleases Brass, If Not All Doctors

How has the medical care of military dependents gone since private physicians took over a large part of it? Defense Department officials report that they're "very, very happy" with the Medicare program. They have, in fact, asked state medical societies to extend their present contracts until next year. Previously, fees and other contractual details had been scheduled for renegotiation this summer.

As a result of the new plan, defense officials will negotiate new contracts with five states a month, beginning in January. The plan is designed to cut the cost of negotiation for the Government.

Defense Department officials have found some kinks in the Medicare program, but for the most part they're minor. One example: The claim form isn't considered simple enough. Another example: The various schedules of physicians' allowances don't always make it clear what specific services

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Such drawbacks obviously haven't interfered with Medicare's popularity among servicemen. The Air Force is said to feel that the program has been responsible for a number of re-enlistments.

Are doctors equally pleased? Not all of them. Some fear that the program will lead to standardized fees. In fact, the Florida Medical Association has voted not to extend its present fixed fee schedule contract, and to seek one without a fixed schedule.

A number of internists want a special fee established for a complete history and physical examination. And many anesthesiologists, pathologists, and radiologists want firm assurance that they can do their own billing. Despite these criticisms, Dr. Dwight H. Murray, outgoing president of the A.M.A., said last month: "In most states the Federal Medicare program is operating successfully."

Here's some indication of how much work civilian M.D.s and hospitals have done under the program. Five months after Medicare got under way:

¶ Nearly 54,000 claims had been filed by physicians; some 37,000, by hospitals.

¶ California led every other state in total claims—both by physicians and by hospitals. Its total topped 14,000. Texas followed with 3,700; Arizona and Florida were third with 2,400 each. [MORE]



"Dramamine nevertheless proved more effective than other methods hitherto employed in the concededly difficult management of nausea and vomiting of pregnancy."

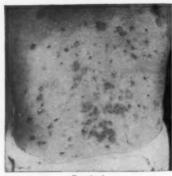
Cartwright, E. W.: Dramamine in Nausea and Vomiting of Pregnancy, West. J. Surg. 59:216 (May) 1951.

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Psoriasis



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MAZON dual therapy

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Belmont Laboratories, Philadelphia, Pa. ¶ The Government had paid out some \$3,666,000 to civilian doctors under the program, and another \$3,562,000 to hospitals. The average doctor's claim thus amounted to \$68.15, while the average hospital's claim amounted to \$96.48.

¶ Maternity cases accounted for some 47 per cent of all services provided under the program.

One note of special interest to doctors: No military station has yet asked for a restriction on dependents' right to choose between military and civilian medical facilities. Under the law, the Defense Department could require dependents to use the military should such facilities find themselves short of patients.

New Book Tells Children What a Hospital's Like

It looks like a picture book for kids—and it is. But "A Visit to the Hospital," just published by Grosset & Dunlap, is also aimed at the parents of small children: Its purpose is to guide them in preparing a child to go to the hospital.

A foreword by Dr. Lester L. Coleman, an otolaryngologist and also a vice president of the Academy of Psychosomatic Medicine, advises parents to "tell your child the truth . . . Give him the reason for his operation; if it is a tonsillectomy, explain that he will then have fewer colds and more time to play . . . Tell him what to

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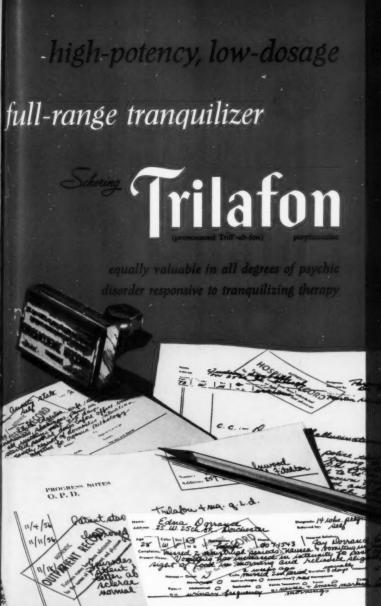
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expect at the hospital. Avoid surprises and confusion."

On this latter count, the book prepared under Dr. Coleman's supervision should prove helpful. It consists mostly of a blow-by-blow account of a tonsillectomy. But Dr. Coleman believes it can be useful in preparing children for any type of surgery.

Malpractice Menace Said To Be Mostly a 'Myth'

The malpractice menace isn't nearly so bad as doctors have been led to believe, according to T. E. Haberkorn, vice president of the Medical Protective Company. Self-styled experts in the malpractice field "have been depicting a dire situation for doctors," he says, "with unsupported statements that . . . as many as 5,000 medical malpractice suits [are] now being filed per year." The true total is less than half that high, he believes.

Actually, Haberkorn notes, it's practically impossible to get the exact total: "It would be necessary to review the court docket of every court in every city, county, and district in the United States." But he believes he has found two yardsticks that, taken together, give a pretty fair measure of the malpractice litigation being started each year:

 "The seventeen states in which the Medical Protective Company operates contain 58 per cent of all (U. S.) physicians. [MORE ►



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With a new SpeedClave she just "Sets It and Forgets It." There are no valves to turn, no waiting, nothing to time, nothing to shut off—everything's automatic! She can load it, set one dial, and go out to lunch.

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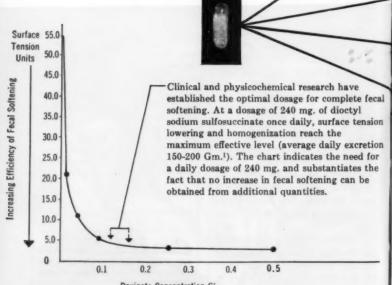
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1. Best & Taylor, The Physiological Basis of Medical Practice, 6th Ed.

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Nearly half the society members in these states insure with the Medical Protective Company. If suits filed against these physicians in 1955 [were] projected proportionately for the entire country, the total would be less than 1,000 . . . only one-fifth of the frightening 5,000 figure . . ."

2. "On a one-state basis . . . [the] legal counsel of the Medical Society of the State of New York [has] reported: 'A total of 229 lawsuits were commenced in the calendar year 1955 which are being defended by your counsel' . . . The society journal had reported 13.539 insured members [belonged to the society's group plan] at the beginning of the year. If this New York experience . . . is projected to the approximately 200,000 physicians in the United States, it would indicate a total of 3,370 medical malpractice suits for 1955.' And this computation, Haberkorn adds, would be "based on possibly the very worst situation in the entire country.

"The true total of medical malpractice suits now being filed annually," he continues, "unquestionably lies somewhere between the 1,000 estimated on the basis of the excellent experience of the Medical Protective Company and the 3,370 estimated on the basis of the dismal . . . experience of the New York State medical society."

Not only is the incidence of malpractice suits lower than generally believed; the court awards that re-

300 MEDICAL ECONOMICS : JULY 1957

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For the modern pregnant woman, just 1 to 3 small, easy-to-swallow capsules daily—according to her individual need—provide generous amounts of iron, calcium and vitamins to help her meet the stress of pregnancy. And they're economical, too—in bottles of 100.

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the MODERN treatment for all 3 types of vaginitis

TRIVA effectively annihilates vaginal microorganisms, restores mucosal integrity and accelerates healing for rapid recovery. Non-irritant, non-toxic, non-staining, TRIVA is a safe, vaginal douche...even during pregnancy. Effective in any pH medium. Most cases of trichomonal, monilial and non-specific vaginitis become asymptomatic and organism free in 6 to 12 days. Simple to prescribe! Just write: "TRIVA (Boyle) sig; douche b.i.d. for 12 days." For complete data see Physicians' Desk Reference, 1956, page 427.

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Full treatment package and literature on request.



BOYLE & COMPANY Bell Gardens, California



sult from them are also lower, Haberkorn says. A review of the last 400 awards in which his company participated "showed the average to be only \$1,757," he reports.

In view of these facts, Haberkorn concludes, "the greatest disservice to the medical profession today is the continued publicity much of it emanating from within the profession itself—that many doctors are doing inferior jobs, that everybody and his brother are suing the doctors, that all doctors carry large insurance policies, and that huge damage awards are becoming the rule rather than the exception. Nothing could do more to bring about that very condition than to give the patient, the damage-suit lawyer, the courts and the juries the impression that those things are true."

Telephone Stenographer Eases Office Problems

Two office items in short supply for today's doctors are adequate space and good medical secretaries. But a pair of dermatologists in Manhasset, N. Y., use an arrangement that, if generally adopted, could ease both shortages.

Dr. George H. Fonde and his partner, Dr. John A. Heinlein, dictate all their letters (120 to 140 a month) over the telephone to an expert part-time medical stenographer who works at home. Every morning the doctors receive from her in the mail the letters dictated

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"It's remarkable how much space you can save by not having another girl in the office," says Dr. Heinlein. "Also, of course, we save on salary. If we had her here full-time, she'd inevitably double as receptionist and errand boy and what have you—jobs that scarcely require a medical stenographer's skill and pay. And she'd never get the letters out so fast."

The stenographer, a housewife with three small children, takes telephone dictation from several other doctors too—"as much as I can handle."

What About Your Records After Your Death?

When a doctor dies, his widow is faced with the question of what to do with his clinical records. "This is no problem if she can sell 'the practice," observes Theodore Wiprud, secretary of the Medical Society of the District of Columbia. "Otherwise, it may become a prolonged source of irritation and worry."

Over the years, Wiprud reports, many widows of physicians have come to him with questions like these:

"Shall I destroy the records? If not, am I obligated to keep them indefinitely? Should I turn them over to the patients if they request it? Is there a moral or legal reason why I should be burdened with





a preliminary report of profound significance concerning new and broadly ramified uses for

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The psychic effect of Marsilid is unparalleled. Neither a "tranquilizer" nor a psychomotor stimulant in the usual sense, Marsilid nevertheless has been shown to possess profound psychodynamic activity with an extraordinary potential for a large segment of the emotionally disturbed population.

what Marsilid is - An isopropyl derivative of isonicotinic acid hydrazide, Marsilid appears to be an amine-oxidase inhibitor, with apparently unique effect as a regulator of serotonin and other neurotropic enzyme activity.

what Marsilid does - Under the influence of Marsilid, severely depressed and regressed apathetic individuals have regained the joy of living, with renewed vigor, activity and interests.

why Marsilid is different - Marsilid characteristically achieves eudaemonia a feeling of healthy well-being - rather than an abnormal state of euphoria. In properly adjusted dosage, it does not produce motor restlessness or irritability, does not depress but may actually stimulate the appetite, Marsilid does not elevate blood pressure.

the Marsilid potential: depressed patients in private practice - Ambulatory, nonpsychotic individuals who are depressed and withdrawn, state that they "again get enjoyment out of life" with Marsilid therapy. Although lesions show only minimal or no changes, patients with chronic debilitating disorders - e.g., rheumatoid arthritis - experience increased vitality and appetite, weight gain, and the return of a sense of well-being; chronic symptoms are better tolerated, less a cause for concern.

the Marsilid petential: institutionalized, psychotic patients - Long-term psychotic patients with severe depression or regression untouched by any previous therapy have shown a heartening response to Marsilid. In some instances, even "deteriorated" schizophrenics of the catatonic and hebephrenic types out of contact with their environment for many years - have become alert, responsive and sociable under Marsilid treatment.

Clinical trials now under way will further delineate the role of this significant new development in therapeutics.

For references and complete information concerning dosage, indications, side effects, and contraindications, write V. D. Mattia, Jr., M.D., Director of Medical Information, Hoffmann-La Roche Inc, Nutley 10, New Jersey.

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ROCHE Original Research in Medicine and Chemistry

MEDICAL ECONOMICS - JULY 1957 307

their responsibility when, at best, it means only bother and expense for which I am not compensated?"

Here are some of the answers Wiprud has given them—in many cases after having "consulted counsel as to legal requirements":

f"It is not illegal to destroy patients' clinical records following the death of a physician. However, their importance to his patients should be taken into account . . . There have been instances where vitally important information about a patient was urgently needed many years after a physician's death . . ."

¶ "Clinical records should not be given to the patient but forwarded to the physician of the patient's choice. These records may contain information which may be misinterpreted or, for medical reasons, had better not be known to the patient."

f"Recent statutory changes providing for . . . tort claims against deceased persons make it . . . prudent to retain clinical records until suits for malpractice cannot be instituted. This [period] varies in the several states," Wiprud points out.*

How can a physician save his widow this trouble? First, by ar-

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^{*}See "How Long Before You're Safe From Suit?" MEDICAL ECONOMICS, June, 1957

Serpasil is one of the safest, least toxic and most effective agents in general practice. Side effects, usually mild, are characteristic of all rauwolfia preparations.

They may, however, be less troublesome than those caused by the whole rauwolfia root, which contains unevaluated constituents as well as reserpine. Complete information furnished on request.

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ranging in advance to sell his practice, Wiprud suggests. If that's not possible, by "making provisions in his will for the disposition of his clinical records. For example, he could stipulate that, unless his practice is sold, these records should be entrusted to a colleague in whom he has confidence and who would be compensated for handling them."

Will Nursing Homes Ease The Bed Shortage?

The U. S. is now short some 880,-000 hospital beds. That means more beds must be established. But it also means "more efficient use must be made of the beds that are available."

That's the opinion of Dr. John W. Cronin, chief of the bureau of medical services of the U. S. Public Health Service. He thinks the following proposal can do a lot toward making more effective use of existing beds:

"Hospitals," he points out, "used to be jumping-off places for eternity. And they were so regarded by the public. Now they're health centers." More and more, he says, they'll tend to include facilities for mental care, diagnostic services, and rehabilitative treatment. What they'll also need, he asserts, is nursing homes—preferably adja-

two reasons for the growing use of **Serpasil**° in everyday practice

Serpasil can always be considered first in hypertension



t

Alone, reduces blood pressure, slowly and safely, in about 70 per cent of mild to moderate cases.\(^1\) As a "primer," Serpasil can advantageously be used to begin therapy, however severe the case, to adjust the patient to the physiologic setting of lower pressure. As a "background" agent throughout other therapy, Serpasil permits lower dosage of more potent agents, thus minimizing side effects. Average Dose: two 0.25-mg. tablets daily for one week, then maintenance on 0.25 mg. or less daily.

 Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955.

One of the safest, least toxic and most effective agents for hyper

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"Not old-age homes," Dr. Cronin emphasizes; but nursing homes that can provide care for the chronically ill, convalescents, and others who are "occupying hospital beds urgently needed for acutely ill patients." In such homes, Dr. Cronin says, patients would receive skilled nursing care; but they'd be under the over-all supervision of private physicians. If necessary, they could be shuttled to the hospital and back, as their medical status warranted.

By using such nursing homes, says Dr. Cronin, patients would save a great deal of money they must now pay to hospitals. More important, hospitals would save a great deal of space. The physician estimates that from 25 to 40 per cent of their beds would be freed for the use of the acutely ill.

Generally speaking, he says, it costs only \$6,000 to erect a bed in a nursing home; the cost of instituting a typical general hospital bed comes to about \$16,000. What's more, the cost per patient day in a nursing home is about one-third the cost of such a day in a general hospital.

Florence, Ariz., provides an example of what Dr. Cronin is recommending. It recently built an eighty-six-bed general hospital and

Serpasil provides true emotional control

Recommended for the many patients who are too nervous or agitated to be adequately calmed by sedatives or weaker tranquilizers. Serpasil actually sets up a "stress barrier" against anxiety and tension these patients would otherwise find intolerable. Average Dose: 0.1 mg. to 0.5 mg. (two 0.25-mg. tablets) daily.

Although it is a first choice in hypertension, Serpasil does not significantly lower blood pressure in normotensive patients.

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ELIXIRS, 0.2 mg. and 1 mg. per 4-ml. teaspoon.
PARENTERAL SOLUTION: Ampuls, 2 ml., 2.5 mg. Serpasil per ml.
Multiple-dose Viols, 10 ml., 2.5 mg. Serpasil per ml.



hypertension and emotional disorders



a fifty-three-bed nursing home alongside it. "We'll see even more such nursing homes in the future," he predicts. And he notes that amendments to the Hill-Burton Act enable the Federal Government to help local sponsors build such homes by paying part of the construction costs.

Doctors Settle Differences In Bowling Alley

For twenty-five years now, doctors in Erie County, Pa., seem to have been unusually successful at getting along with each other. The reason? It's simple: They bowl together. Back in 1932, some two-

score Erie physicians organized a medical bowling league. Since then, 225 different doctors have been members—a number roughly equivalent to the present membership of the whole county society.

"There is no question," says the league's silver anniversary report, "that this bowling league has been the number one factor in promoting the high level of good intraprofessional . . . relations . . . enjoyed by our county medical society. Many of the petty differences of opinion among our members have been solved in the bowling alleys."

Erie's doctor-bowlers have long sought to convert other physicians

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to bowling—mostly without success. At the A.M.A. convention in 1941, they were instrumental in organizing the American Medical Bowling Association; but it fizzled out after one tournament. (Erie made a clean sweep.) More recently, Erie sent challenges to every county society in the country. There were no takers.

Briton Solves 'Mystery' Of Organized Medicine

If you've wondered about all the things the A.M.A. does, you may be enlightened by a recent analysis of its British counterpart. The British Medical Association "has so many irons in the sacred flame of medicine that it's difficult to say what it does do," says a young British doctor writing under the pen name of Richard Gordon in Punch, the humor magazine. Here's his attempt to solve "the widespread mystery" of the B.M.A.'s functions:

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"Above all, it organizes committees. The B.M.A. is crawling with committees ready to give advice on anything from abortion to zymotic diseases to anyone from a Royal Commission to the Boy Scouts. This is most beneficial to the profession. A doctor would outrage his busy partner by popping down to London for the day with dinner

more reasons for the growingse

in tachycardia Serpasil slows the rapid heart

By prolonging diastole and allowing more time for the myocardium to rest, Serpasil enhances blood flow and cardiac efficiency.

R 0.1 mg. to 0.5 mg. (two 0.25-mg. tablets) daily.

in alcoholism

Serpasil relieves drink-inducing tension

Long-term therapy with oral Serpasil helps the alcoholic "stay on the wagon," makes him more amenable to counseling. Parenteral Serpasil generally controls delirium tremens within 24 hours.

R Chronic phase: two 0.25-mg. tablets or less daily. Acute phase: two 2.5-mg. parenteral doses (1 ml. each) 3 or 4 hours apart. Occasionally, repeat injections may be necessary every 4 to 6 hours.

in premenstrual tension Serpasil controls the "cyclic" change in personality

In the many women who become irritable, easily fatigued and apprehensive as the menstrual period approaches, Serpasil exerts a calming effect which moderates their periodic change in personality.

R 0.25 mg. b.i.d., beginning 10 days before expected onset of menses.

and a show afterwards. But if he looks into the subcommittee on Microscopical Ethics everyone's happy and he gets the relaxation that puts off his coronary thrombosis."

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Another function of the B.M.A. is high-level negotiation with the Government, Dr. Gordon points out. Individual British doctors "naturally feel chary of queueing up with the unions for more cash." he says. "But the B.M.A. can put in a pay claim like a bishop on a good cause. It has only to talk to the Minister of Health about professional remuneration with the touch of dignified distaste suggesting an unpleasant disease discovered among his relatives, and . . . there [he is], wondering how the devil to get out of it."

It's also the function of the B.M.A. to publish a professional journal. "Once a week," Dr. Gordon notes, "almost every G.P. in the country wakes to hear the welcome thump of the British Medical Journal on his doormat. This tells him that it's Saturday and there's only a few hours to go before he can reach for his golf clubs and forget about medicine altogether ... "

Among the services the Journal provides is "a racy section headed 'Any Questions?' This gives cutrate second opinions for the cost of a postcard . . . The rest of the jour-

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in hypertensive crises Serpasil saves lives

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in acute psychotic disturbances Serpasil permits discreet management

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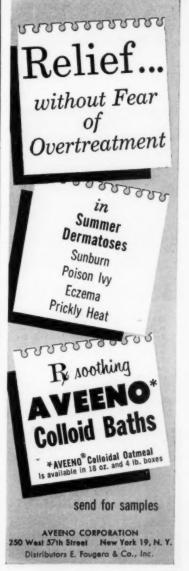
All in all, Dr. Gordon concludes, the B.M.A. "does its members a power of good by giving them a chance to let off steam. Doctors are lonely men. Under professional rules they can't even talk about their work to their friends. Just think what their wives would have to put up with were it not for the B.M.A."

Better Health Insurance Seen for the Aged

How many people over 65 now have health insurance? According to J. F. Follmann Jr., research director of the Health Insurance Association of America, the answer is at least one out of three—and the ratio is getting better all the time.

There are at least six distinct trends among insurance companies, Follmann continues, toward insuring people over 65. Here's how he lists them:

1. "Older workers are getting the same group insurance as young workers. A 1954 survey of forty-three companies showed that thirty-seven of them make no discrimination on the basis of age when they write group insurance policies."



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2. "Group insurance benefits are being continued for retired employes and their dependents. The same 1954 survey showed thirtysix companies writing this kind of coverage."

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3. "People with group coverage are being allowed to continue their insurance on an individual basis when they leave the group. This is now general practice in the field

of group insurance."

4. "Individual insurance policies are being continued into old age. When 186 companies were recently queried about this, half of them replied that they'd consider continuing policies up to any age. Another fifteen said they'd continue coverage until age 75."

5. "There's also a growing tendency to issue new policies at advanced ages. Of the same 186 companies. 106 reported they would consider new risks for hospital insurance above age 60."

6. "Finally, one company is now selling individual health insurance that becomes paid up by age 65.



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The idea is for the policyholder to pay the whole cost of his insurance during his productive years, but to keep the benefits as long as he lives. The increase in premiums is about 5 per cent for those who buy their policies when they're young; it's about 30 percent at age 55."

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Follmann sees the sixth trend as "most significant," since it offers a possible solution to the fundamental problem in health coverage for the aged: the fact that retired people, who need such insurance more than anybody else, usually can't afford to keep up the payments.

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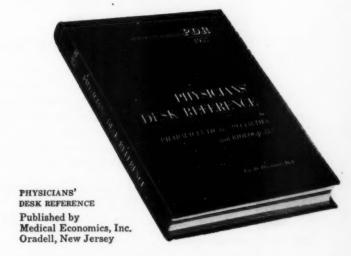
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References: 1. Beierwaltes, W. H.: J. Michigan M. Soc. 55:180 (Feb.) 1956. 2. Frawley, T. F.; McClintock, J. C.; Beebe, R. T., and Marthy, G. L.: J.A.M.A. 160:646 (Feb. 25) 1956.

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Conversational Style

In a new book on medical writing, Dr. Henry A. Davidson says: "A doctor in staff-room or parlor conversation talks simply. Yet when scratching that itch to write, he often develops a fondness for fancy language. He wants to be impressive. Instead, he is hard to understand . . ."

This rang a bell with us. If you think about it, you'll probably agree that whatever success MEDICAL ECONOMICS has had in making difficult subjects easy to understand can be traced to its conversational style. Our editors' blue pencils work overtime on formal literary writing. They seek to make our articles clear, terse, and lively—the way most people talk.

In this they're guided by some "Suggestions for Contributors" that were drawn up by the editors years ago. You may be interested in a few of them:

¶ "Get over the complex that makes people write long, tiresome introductions. Get down to brass tacks as quickly as possible and don't let up . . .

¶ "Write on the assumption that the reader is not interested in what you have to tell him—that his attention depends solely on the worthwhileness of what you have to say and the vigor with which you say it . . .

¶ "Don't forget that your reader is interrupting you every ten lines to ask: Why? What for? Well, what of it? If you don't answer his questions, he will soon stop reading . . .

¶ "Whenever possible, write from actual experience—your own or someone else's. Tell how a thing has been done rather than how it should be done..."

These ideas are no news to most people who write for a living. Strangely enough, though, the same cues come in handy when writing letters, when speaking in public, or even in ordinary conversation.

Perhaps that explains the appeal of conversational writing—the sum and substance of MEDICAL ECONOMICS style.—LANSING CHAPMAN

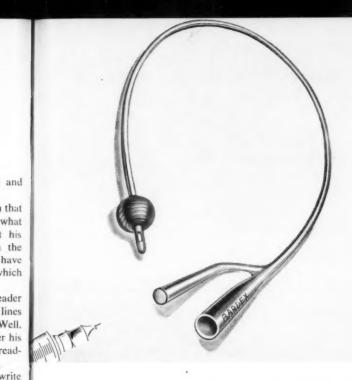
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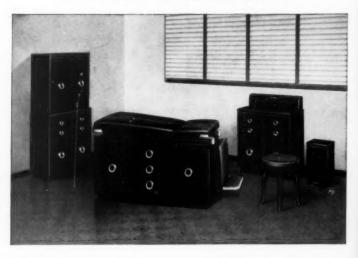
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